Maternal and Child Health Services
Title V Block Grant

State Narrative for Nebraska

Application for 2010
Annual Report for 2008

Document Generation Date: Monday, September 28, 2009

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications, signed by the CEO, Nebraska Department of Health and Human Services (DHHS), are maintained in the administrative files for Nebraska Title V/MCH Block Grant located in DHHS, Division of Public Health, Lifespan Health Services, Planning & Support. The documents may be inspected by contacting the Title V/MCH Grant Administrator, (402) 471-0197 during regular business hours Monday-Friday, 8:00 a.m.-5:00 p.m. Central Standard Time, or sending a written request to Nebraska Department of Health and Human Services, Division of Public Health, Lifespan Health Services, Planning & Support, P.O. Box 95026, Lincoln, Nebraska 68509-5026.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

A 50-member stakeholder group first organized in 2003 to bring a public perspective to the five-year needs assessment process. Representation was diverse and included consumers, state legislative from various settings including local health departments, community action agencies, hospital, and academia. Participants represented rural and urban, and included racial/ethnic minority populations of Native Americans, African Americans, and Hispanics. The group met during 2003 - March 2005 when the priorities were established. In 2005, five work groups reviewed data of subpopulations, each meeting three times to identify and present significant problem statements for the large group prioritization meeting in March. Group consensus was achieved. Data sheets are posted at http://www.hhs.state.ne.us/fah/RFP.htm.

The priorities established through this mechanism of public input were used to guide funding decisions for state- and community-level funding obligated in June and August 2005 for the fiscal beginning October 1. In addition, members of the stakeholder group will be invited to additional meetings planned by the Office of Family Health beginning in Fall 2005 to expand public input to include strategy development centered on the priorities. /2007/ Strategic planning was postponed to Fall 2006. The stakeholder group from the needs assessment will reconvene then, and additional public input will be sought as warranted by the priorities. The Family Health web site also includes a link for public input into the application each year. //2007//

/2008/ Stakeholders were convened in September 2006 to launch Nebraska's MCH/CSHCN Strategic Planning process. Subsequently, three work groups were formed early in 2007. This planning process continues to be an important conduit for gathering public input on priority strategies for addressing the needs of Nebraska's MCH and CSHCN populations. In addition, the Nebraska Health and Human Services web site included a link on the Office of Family Health

home page for provision of public comments.//2008//

/2009/ The outcomes from the three stakeholder work groups whose problem analysis and strategy development was completed in late 2007 were instrumental in shaping the direction of the next three-year funding cycle FY 2009-2011. A Public Notice seeking input on DHHS' application to the federal government for Title V/Maternal Child Health Block Grant funds for the period of October 1, 2008 - September 30, 2009 was published in the Lincoln Journal Star, a daily newspaper with statewide coverage. A brief written document entitled "Guidelines for Input" were available upon request by calling toll-free (800) 801-1122, and continue to be available on the DHHS web site http://www.dhhs.ne.gov/LifespanHealth/planning/. No comments were submitted. //2009//

/2010/ Informally, Lifespan Health Services continually seeks input from organizations with funding and programmatic relationships to MCH and CSHCN in Nebraska, and is readily welcomed from the general public. In an interim year such as this, DHHS formally sought public input primarily on the application. As usual, a Public Notice was published in the Lincoln Journal Star, a newspaper with statewide distribution. The usual practice of posting an announcement on the Planning & Support web page was enhanced in the past several years by the site's new ability to automatically send an email alert when there is a revision to a webpage to which persons subscribe. To help with the request, we again used a three-page document entitled "Guidelines for Input" and referred to it in the newspaper and on the webpage.

Two new methods this year to formally elicit public input were: 1) providing the link to the 2009 Nebraska Title V Application on the HRSA website to readily give the framework for which input would be incorporated and the type of input sought, and 2) sending an email request to stakeholder groups in Nebraska. Organizations were asked to continue forwarding the request and to work with individuals and families to assist them with their personal input. The text of the email read:

"DHHS is preparing to submit its annual application (2010) and report (2008) to the federal awarding agency for Title V/MCH Block Grant. The application addresses statewide health needs of women, infants, children, and adolescents, and their families, including children with special health care needs. Public input on the application is required by federal statute. Public input assists DHHS to better plan for ensuring good health for these Nebraskans.

We are seeking help from our partners to encourage input from your organization and your family contacts. Also, please forward this request to other organizations to seek input from the public/community. Input can be given at any time, but comments received by July 1, 2009 will be reviewed and considered for the application.

Guidelines for Input and a link to the most recent application / report can be found at: http://www.dhhs.ne.gov/LifespanHealth/planning/. Questions should be directed to Rayma Delaney, DHHS, TitleV/MCH Grant Administrator at (402) 471-2907 or email at lifespan.health@dhhs.ne.gov."

To stay within the character limits of this section, the "Guidelines for Input" is not reprinted here, but is available at the webpage indicated in the previous paragraph. We did receive public input from three organizations. It is believed the input was the direct result of taking the two additional steps to elicit public input, i.e. the email outreach to stakeholders and the link to the 2009 Nebraska Application. Their comments and suggestions are incorporated into the 2010 Application. //2010//

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

There have been no changes to Nebraska's ten priority needs in the past year. Although, there have been several activities that relate to the needs assessment process. The first is the capacity building activities of local MCH assessments and the second is an action planning effort to initially address three of the ten priorities.

The local assessment activities have been funded through the block grant with the intent of building core public health capacity around assessment, to increase the ability of local health departments (LHD) to partner and collaborate with maternal and child health community locally and at the state level, and to build local data/expertise into the 2010 needs assessment process. To date nine local health departments are involved in the MCH assessment process with varying degrees of success. It is still unclear if/how local data will be gleaned for the statewide process. However, the ability of the LHD's to effectively participate in the up-coming assessment has been enhanced.

Nebraska kicked off strategic planning activities around the ten priority needs in September, 2006 with a technical assistance consultation from Family Health Outcomes Project (FHOP) contractors/University of California, San Francisco. The event pulled together over 100 stakeholders to introduce the methods and invite participation into small work groups. Based on stakeholder input, staff time/resources, and other activities taking place within the agency three priorities were selected to form workgroups

1. Reduce the rates of overweight women, youth, and children by increasing participation in sufficient physical activity and improving nutrition.
2. Reduce rates of premature and low birth weight births for all women, with attention to adolescent pregnancy.
3. Build capacity of Title V programs for Children with Special Health Care

Needs to provide transition medical and dental clinics for youth with special health care needs 14-21 years.)

All three workgroups have reviewed the current literature and updated needs assessment data to thoroughly analyze the problem/need. They have produced problem analysis diagrams and are currently transitioning in to logic model work. The end product will be a collaborative action plan. Additional, workgroups may then form around infant mortality and intentional injury.

Finally, over the upcoming year staff will begin to establish work plan for the 2010 needs assessment.

/2009/ the following summary was omitted in the past.

In 2004, staff collected and analyzed data from over 400 Maternal and Child Health Indicators. Data was analyzed by trends, disparities, and comparisons with national and HP2010 benchmarks. The Needs Assessment Committee (NAC) then formed and followed a process set forth by University of North Carolina, Program Planning and Monitoring Self-Instructional Manual, "Assessment of Health Status Problems" and described in the University of California at San Francisco Family Health Outcome Project (FHOP) "Developing an Effective MCH Planning Process: A Guide for Local MCH Programs". The steps followed by the NAC were:

1) Set the Objectives and Process of Prioritization,
2) Select Prioritization Criteria,

3) Develop Criteria Rating Scales,
4) Determine Weights for Each Criterion,
5) Convene workgroups,
6) Workgroups review data and identify problems/needs
7) Presentation of identified problems and data summary from all workgroups to the larger planning committee,
8) Agreement on the final problem list to be prioritized,
9) Use Weighted Criteria to Score Problems,
10) Sum Participant's Scores/Rank Problems,
11) Discuss and Confirm Ranked Results

This process resulted in the following 10 priority needs:

1. Reduce the rates of overweight women, youth, and children by increasing participation in sufficient physical activity and improving nutrition.
2. Reduce the percent of women of child-bearing age, particularly pregnant and post-partum women, and adolescents who use tobacco and reduce the percent of infants, children and youth exposed to second hand smoke.
3. Reduce rates of premature and low birth weight births for all women, with attention to adolescent pregnancy.
4. Reduce the rates of hospitalizations and deaths due to unintentional injuries for children and youth.
5. Reduce the number and rates of child abuse, neglect, and intentional injuries of children.
6. Reduce the rates of infant mortality, especially racial/ethnic disparities.
7. Reduce alcohol use among youth.
8. Increase capacity of community-based medical home providers to detect and refer for treatment women, children, and youth with emotional and behavioral health conditions.
9. Increase capacity of Title V Programs for Children with Special Health Care Needs to serve increased numbers of children meeting medical and financial eligibility criteria and who are uninsured or underinsured.
10. Build capacity of Title V programs for Children with Special Health Care Needs to provide transition medical and dental clinics for youth with special health

Staff continued to assess priorities number one, three, and ten through problem analysis and logic model work with stakeholders (the report is attached). Assessment and analysis of number six is on-going it is probable that staff will look deeper into this priority in 2009. There are no changes to report in the 10 identified needs. An internal committee will form in 2009 to begin on the 2010 Needs Assessment. //2009//

/2010/ Over the past year, the SSDI director has been preparing to conduct the 2010 comprehensive needs assessment by attending a December training conducted by AMCHP in conjunction with the annual MCH Epidemiology conference in Atlanta, participating in the CDC sponsored PRAMS Course on utilizing PRAMS data analysis in needs assessments, reviewing methodology of other states, identifying staff and stakeholders participants and requesting a summer intern. Currently, Nebraska has a GSIP summer intern assigned to assist with data collection, assembly, analysis and preparing communication and other products for the fall stakeholder meetings. //2010//

III. State Overview

A. Overview

Principal characteristics of Nebraska important to understanding the health needs of the entire state's population.

a. Large geographic area

Nebraska is located in the east-central area of the Great Plains midway between New York and San Francisco. Nebraska is generally rectangular in shape with a protruding area in the northwest corner called the Panhandle. The Missouri River bounds the eastern border between Nebraska and Iowa. Missouri, Kansas, Colorado, Wyoming and South Dakota surround Nebraska on the other borders. The State measures 387 miles across, including the western panhandle. The diagonal from northwest to southeast measures 459 miles, and the southwest-northeast diagonal is 285 miles. The state's area is 77,227 square miles, almost 20% larger than all of New England.

Nebraska's large land expanse creates unique health service delivery issues. In rural counties, about 18% of the population are 65 and over, and in 37 counties, the number of persons over age 65 exceeds 20%. This trend has important implications for the delivery of health and medical services because an older population needs more services

Nebraska's population centers are Omaha, Lincoln and several smaller cities scattered along the Platte River and Interstate 80 (which together bisect the state from east to west). Only Omaha and Lincoln (60 miles apart) represent Metropolitan Statistical Areas (MSAs) larger than 50,000 population.

b. Urban and rural

The total population of NE is projected to grow 11% by 2020. Although Nebraska's total population has grown considerably during the 1990s, many small rural counties that are not near a regional economic or health center continue to decrease in size. Most of the decrease in these counties resulted from out-migration of the younger population (18 to 45 years). Smaller population bases make it more difficult to recruit and retain physicians and other health care professionals. A small population base also makes it more difficult to operate institutional services, such as hospitals, and finance other types of services such as mental health, public health, emergency medical services, and long-term care services.

Nebraska's geography shows the state to be a primarily rural and sparsely populated state by national standards, with 32 out of 93 counties as frontier counties (6 or fewer persons per square mile). In contrast, approximately 50% of the state's citizens reside in the population centers of Lincoln and Omaha in the eastern part of the state. The urbanization of Douglas and Sarpy County (Omaha), and Lancaster County (Lincoln) is represented by an average population increase of over 10% between 1990 and 1998.

c. Increasing diversity

Another source of change is Nebraska's rapidly increasing diversity in a state previously regarded as homogeneous. Nebraska currently has its highest percentage of foreign-born residents since the 1870's. Minority populations are growing rapidly in both urban and rural parts of Nebraska. According to the US Census, the state's minority population grew by 23% between 1980 and 1990, and racial/ethnic minorities were found in every Nebraska County. From 1990 to 2000, the minority population rose by 83.5% (from 118,162 to 216,769) and now constitutes 12.7% of the total population while the white population increased by 2.2%. Most of this increase in minorities is Hispanic, whose numbers increased 255%, 40% of the state's overall population increase. However, they are not alone. Nebraska may have one of the largest Sudanese communities in the country. Numbers of Sudanese, Somalian, Bosnian and Vietnamese residents have jumped over the past decade.

In general, the minority population tends to be younger, have lower incomes, higher poverty, and less insurance coverage. They are also more likely to be employed in high-risk occupations such as meat packing plants and farm labor. As a result, these population groups often experience difficulty gaining timely access to health and medical services. Even when services are available, language and cultural barriers prevent effective utilization of these services. There is a need to optimize these services for minority populations using culturally sensitive tools.

Nebraska's vision of healthy individuals, families and communities can only occur if racial and ethnic minority populations have equal opportunities for good health. To bridge the gap between the wide disparities in the health status of racial/ethnic minorities and the white population, it is essential to address the high risk factor prevalence, the major barriers that limit access to high quality health care services, and the need to develop effective local public health services across the state.

(1) Immigration
(a) Hispanic origin
The largest minority group in the state is the Hispanic American population which experienced the most dramatic increase by more than doubling from 37,200 in 1990 to 106,918 in 2003 (a 187% increase) according to the U.S. Census estimates. Hispanic Americans now comprise 6.1% of the state's population. Douglas County, in 2000, had a Hispanic population of 30,928 people. Not surprisingly, these are the highest numbers in the state.
/2007/Hispanic American population which experienced the most dramatic increase by more than tripling from 37,200 in 1990 to 119,975 in 2004 (a 222.5% increase) according to the U.S. Census estimates. Hispanic Americans now comprise 6.8% of the state's population.//2007//

/2008/Hispanic American population which experienced the most dramatic increase by more than tripling from 37,200 in 1990 to 132,371 in 2006 (a 256% increase) according to the U.S. Census estimates. Hispanic Americans now comprise 7.4% of the state's population.//2008//

/2009/Hispanic American population which experienced the most dramatic increase by more than tripling from 37,200 in 1990 to 140,432 in 2007 (a 277% increase) according to the U.S. Census estimates. Hispanic Americans now comprise 7.9% of the state's population.//2009//

The Hispanic American population is expected to increase considerably by 2025. It is estimated that the number of Hispanic Americans in the state will reach 145,000 by 2025, an increase of 36% of the current population estimate. With the availability of employment, the Hispanic population in the central and western part of Nebraska has increased considerably. According to the U.S. Census, Dakota, Dawson, Colfax, Scotts Bluff, Hall, and Morrill counties have a Hispanic population greater than ten percent.

(b) Asian and Pacific Islander
Nebraska's Asian and Pacific Islander (API) grew from a population in 1990 of 12,629 to 29,058 in 2003, according to the U.S. Census Bureau estimates. The Asian/Pacific Islander population is expected to increase considerably by 2025. The Census Bureau estimates that this population will reach 40,000 people, an increase of 38%.
/2007/Nebraska's Asian and Pacific Islander (API) grew from a population in 1990 of 12,629 to 27,922 in 2004, according to the U.S. Census Bureau estimates.//2007//

/2008/Nebraska's Asian and Pacific Islander (API) grew from a population in 1990 of 12,629 to 33,890 in 2006, according to the U.S. Census Bureau estimates.//2008//

/2009/Nebraska's Asian and Pacific Islander (API) grew from a population in 1990 of 12,629 to 36,767in 2007, according to the U.S. Census Bureau estimates.//2009//

(2) Native American
The Native American population in Nebraska grew by 15.7%, from 12,874 in 1990 to 16,298 in 2003, according to the U.S. Census estimates. Native Americans currently comprise 0.9% of Nebraska's total population. Thurston County, home of the Omaha and Winnebago Tribes, ranks number 26 in the U.S. for percentage Native American. Almost half of the county's population is Native American (52%). Four federally recognized Native American tribes are headquartered in Nebraska, the Santee Sioux, Omaha, Winnebago, and Ponca. The Native American population is expected to increase considerably by 2025. Nebraska's Native American population will increase to 25,000 people, an increase of 53%.
/2007/The Native American population in Nebraska grew by 28.6%, from 12,874 in 1990 to 16,562 in 2004, according to the U.S. Census estimates.//2007//

/2008/The Native American population in Nebraska grew by 58%, from 12,874 in 1990 to 20,344 in 2006, according to the U.S. Census estimates.//2008//

/2009/The Native American population in Nebraska grew by 62%, from 12,874 in 1990 to 20,846 in 2007, according to the U.S. Census estimates.//2009//

Though many of Nebraska's Native Americans live on reservations, the majority does not. The urban areas of Omaha and Lincoln account for more than 33% of the state's Native American population, although they make up only a small proportion of these counties' total populations. A sizable group also exists in the northwestern part of NE adjoining the Pine Ridge Reservation in South Dakota. Among the state's reservations, the Winnebago and Omaha reservations in Thurston County account for 22% of Nebraska's Native American population. An additional 3% reside at the Santee Sioux Indian Reservation in Knox County. The Iowa and the Sac and Fox Indian Reservations on the Nebraska-Kansas border account for about 1% of Nebraska's Native American's total population.

(3) African American
African Americans make up 4.0% of the Nebraska population. This population grew from 58,047 in 1990 to 68,541 in 2000, an 18.1% increase. The African American population is expected to increase considerably by 2025, with growth projected at 63% (to 109,000 people). Almost 90% of Nebraska's African American population are located in the most populous counties (Douglas, Sarpy and Lancaster). This growth is fueled by a large number of African immigrants, particularly from Sudan and Somalia; Nebraska may have one of largest Sudanese communities in the country.

/2007/African Americans make up 4.3% of the Nebraska population. This population grew from 58,047 in 1990 to 74,815 in 2004, an 28.9% increase.//2007//

/2008/African Americans make up 4.7% of the Nebraska population. This population grew from 58,047 in 1990 to 83,557 in 2004, an 43.9% increase.//2008//

/2009/African Americans make up 4.8% of the Nebraska population. This population grew from 58,047 in 1990 to 84,853 in 2004, an 46.2% increase.//2009//

(4) Minority Health Professionals
Cultural differences can and do present major barriers to effective health care intervention. This is especially true when health practitioners overlook, misinterpret, stereotype, or otherwise mishandle their encounters with those who might be viewed as different from them as they do their assessment, intervention, and evaluation. Health care professionals' lack of knowledge about health beliefs and practices of culturally diverse groups and problems in intercultural communication has led to significant challenges in the provision of health care services to multicultural population groups. The cultural diversity of the health care workforce itself can present problems that can disrupt the provision of services because of competing cultural values, beliefs, norms, and health practices in conflict with the traditional Western medical model.

While Nebraska has become an increasingly diverse state, its medical practitioners have not. In 2002, only about 1.2% of Nebraska physicians was African American, although this group makes up 4% of the state's population. This is less than the U.S. average; approximately 4% of all US physicians are African American. Only six Native American physicians practice in NE (0.2% of all physicians) yet this minority group makes up 0.9% of the population.

People of Hispanic origin comprise 6.1% of the state's population and are the fastest growing population group, but account for only 1.3% of Nebraska physicians. Asian Americans are well represented in the physician population. This group makes up only 1.7% of the population of the state, but accounts for 5.3% of physicians.

Additional barriers of receipt of health care were identified for racial and ethnic minority women in Nebraska. One-third of Asian American women (34%) and 12% of Hispanic women reported that language "always," "nearly always," or "sometimes" kept them from getting needed health care, according to a Nebraska Minority Behavioral Risk Factor Survey (NMBRFS).

Respondents to the NMBRFS were asked whether or not they felt racial or ethnic origin is a barrier to receiving health care services in their county. Nearly half of African American women (45%), 40% of Native American and 38% of Hispanic women "strongly agreed" or "agreed" that race or ethnic origin is a barrier. More than one-fourth (28%) of Asian American women expressed agreement with this statement.

(5) Racial and ethnic health disparities
As in other states, Nebraska's minority population has many health disparities. For example, according to an September 2003 report from the NHHSS Office of Minority Health, life expectancy for a Nebraska woman who is white is almost six years longer than for a Nebraska woman who is African American and more than ten years longer for a Nebraska woman who is Native American. African Americans have the highest rates of low-weight births and infant deaths in Nebraska. Native Americans in the state are five times more likely to die of diabetes-related causes than white persons. The CDC's "Women and Heart Disease: An Atlas of Racial and Ethnic Disparities in Mortality" showed that Nebraska has one of the highest heart disease death rates in the country for African American and Native American women.

d. Aging population
Another significant trend is the aging of the state's population. In 2000, the percentage of the population aged 65 and older was 13.6%, compared to the national average of 12.4%. The total number of Nebraskans over age 65 increased by 4.1%, or by 9,127 individuals, from 1990 to 2000. Nebraska ranks 11th in the nation for percentage of population 65 years and over, however NE ranks only 44th in the nation for percentage change from 1990 to 2000. The population over 65 is projected to grow 48% by 2020. Nebraska ranks 6th in the nation for percentage of the population aged 85 years and over at 2.0%. This is a slight increase from 1990 (1.9%). The total number of people aged 85 and over increased by 4,751 individuals, or by 16.3%. NE ranks 50th in the nation for percentage change from 1990 to 2000.

In rural counties (those with populations of less than 20,000 people) about 18% of the population is 65 and over and in 37 counties the number of persons over age 65 exceeds 20%. Hooker County, Nebraska, ranks 2nd of all U.S. counties for percentage of population over 85 years of age at 6.3%. Nebraska has 17 counties (18%) of its counties in the top 100 of all U.S. counties for percentage of population over 85 years of age. The median age of Nebraskans increased from 33.0 in 1990 to 35.3 in 2000.

This trend has important implications for the delivery of health and medical services because an older population needs more services. However, a shrinking total population base reduces the number of people in the service area. The net result is that fewer health and medical services are available to meet the needs of the population. These inadequate services are further

compounded by the lack of public transportation services in most rural areas of the state. As Nebraska struggles to maintain health care delivery in rural areas, services for older adults become increasingly fragmented and challenging.

e. Special populations

(1) Incarcerated

In Nebraska the average number of women incarcerated is 254. Using national estimates, 63% of incarcerated women have at least one minor child, and approximately 40% have more than one child under age 18. Nationally, 2.1% of the nation's children had a parent in State or Federal prison. African American children were nearly 9 times more likely to have a parent in prison than white children. Hispanic children were 3 times as likely as white children to have an inmate parent. The number of children with a mother in prison nearly doubled since 1991, while the number of children with a father in prison grew by 58% during this period.

/2008// According to Nebraska Department of Corrections there were 418 incarcerated women in 2006, 9.6% of those incarcerated were women which is higher than the national rate of 7.1% (2002). According to the US Department of Justice 70% of incarcerated women has children under the age of 18, and 2.8% of the nation's children had a parent in State of Federal prison in 2000. The Department of Justice estimates the 85% of the female correction population are being supervised in the community.//2008//

/2009/ According to Nebraska Department of Corrections there were 382 incarcerated women in 2007, 8.7% of those incarcerated were women which is lower than the national rate of 12.8% (2007). //2009//

(2) Homeless

The Nebraska Homeless Assistance Program (NHAP) makes funds available to nonprofit organizations through grant awards in order to serve the needs of people who are homeless and near homeless in the state. According to NHAP data, 20,307 people were homeless in Nebraska during the grant year July 2003 to June 2004 and 31,024 people were near homeless during this same time period. These figures include 12% homeless/8% near homeless unaccompanied women, 4% homeless/2% near homeless unaccompanied youth, and 39% homeless/54% near homeless single parent families. During the grant year, Hispanic or Latino persons represented 17 % of persons who were homeless and 11% of those who were near homeless. This year, during the first six months of the grant cycle (July 1, 2004-December 31, 2004), the same agencies and programs assisted 24,099 persons who were homeless and 34,826 who were at imminent risk of homelessness. Both figures exceed those assisted in each category during the prior grant cycle. It is important to note that the data is limited to numbers provided by monthly NHAP Reports received from NHAP programs statewide.

/2008/ According to NHAP data, 34,143 people were homeless in Nebraska during the grant year July 2005 to June 2006 and 54,064 people were near homeless during this same time period of which 22% homeless/11.3% near homeless unaccompanied women, and 2.3% homeless/1.7% near homeless unaccompanied youth. During the grant year, Hispanic or Latino persons represented 14.5 % of persons who were homeless and 15.9% of those who were near homeless. //2008//

/2009/According to NHAP data, 23,743 people were homeless in Nebraska during the grant year July 2006 to June 2007 and 32,122 people were near homeless during this same time period of which 22% homeless/11.3% near homeless people were near homeless during this same time period of which 22.6% homeless/10.9% near homeless unaccompanied women, and 2.1% homeless/1.8% near homeless unaccompanied youth. During the grant year, Hispanic or Latino persons represented 16.2 % of persons who were homeless and 17.4% of those who were near homeless. The overall number of persons homeless or near homeless is a significant decline due to the full implementation of a statewide computer tracking system which represents an unduplicated count compared to a hand count in previous years were individuals and families

were potentially seen in multiple agencies across the state. //2009//

f. Rural poverty
Five of the nation's 12 poorest counties in 2002 were in Nebraska (US Dept. of Commerce). Loup County ranked as the nation's second poorest (per-capita income of $9,281 vs. national per-capita income of $30,906).

2. Agency's current priorities and initiatives with Title V programs' roles and responsibilities.

A description of the Agency's priorities and initiatives first requires an understanding of changing organizational structure. ***/2010/ Several changes in this structure have occurred over the past five years. The cumulative narrative provided in Nebraska's annual report and application since FFY 2005 has been deleted, and a summary of the current organizational structure is being provided for the FFY 2008 report/FFY 2010 application.***

During the 2007 legislative session, LB 296 was passed and signed into law by the Governor. This bill regorganized the three agencies that formerly formed the Health and Human Services System into one agency: the Department of Health and Human Services. This new structure went into effect July 1, 2007. The single agency is headed by a Chief Executive Officer. The Department has six divisions: Public Health, Behavioral Health, Children and Family Services, Developmental Disabilities, Medicaid and Long Term Care, and Veterans Homes. Title V/MCH functions are located in the Division of Public Health. Title V/CSHCN functions are within the Division of Medicaid and Longterm Care, Safety and Independence Supports Unit. Reorganization also occured within the Division of Public Health, including the combination of the Office of Family Health and the Office of Women's Health, forming Lifespan Health Services. Throughout this application, references to the former Health and Human Services System and the three former agencies in the system have been replaced with the current agency name, DHHS. References to the Office of Family Health have been changed to Lifespan Health Services Unit.

The Division of Public Health established five priority areas: wellness, eliminating disparities, data capacity, effective public education and use of the media, and budget transparency.//2010//

Overlaying these established agency priorities are a number of issues that emerged in FFY 2004 and continue to be of importance to DHHS, including the Lifespan Health Services Unit and Safety and Independence Supports Unit. Child Protection Reform was initiated with the passage of LB 1089 in April 2004. This funding bill allocated $5.5 million for 120 new protection and safety workers, and another $350,000 for case coordinators. Additional funds were also made available for enhancements of the Criminal Justice Information System and other related activities. Then, during the 2005 legislative session, LB 264 was passed, which adds secondary prevention as a social service that may be provided on behalf of recipients under the Social Security Act. In addition, $200,000 per year was appropriated specifically for home visitation services. ***/2010/ Funding for home visitation as secondary prevention of child abuse and neglect is currently at $600,000 per year.//2010//***

The Lifespan Health Services Unit is actively partnering with NE HHS Protection and Safety staff in addressing issues of child abuse prevention. Currently underway is the development of a child abuse prevention plan, described in more detail in Section IV B, State Priorities./2008/The Child Abuse Prevention Plan was released in August 2006, and Lifespan Health Services continues to work with Protection and Safety and the Nebraska Children and Families Foundation in its implementation.//2008//

Also enacted in 2004 was enabling legislation for mental health reform. This law established the Behavioral Health Division within HHS and created a State Behavioral Health Council. The focus of this system reform effort has been to ensure statewide access to behavioral health services; ensure high quality behavioral health services; ensure cost-effective services; and ensure public safety and the health and safety of persons with behavioral health disorders. The immediate goal of the reform initiative has been the movement of behavioral health from institutional care to community-based services for persons with chronic and severe mental health disorders. In FFY 2005, Nebraska Health and Human Services has had the opportunity to do related work specific to children's mental health. Nebraska is the recipient of a 5-year, $750,000/year State Infrastructure Grant (SIG), awarded by SAMHSA, which is focusing on enhancing and building capacity for children's mental health services. Both the Lifespan Health Services and Safety and Independence Supports Units had been actively involved in early activities of the SIG grant through participation in an internal stakeholders group.

/2007/ During FY 2006, SIG activities included the development of recommendations specific to early childhood mental health. The Nebraska Title V/MCH Director was active in the work group developing these recommendations, and provided a direct link to and assured coordination with Nebraska's perinatal depression screening project. The Nebraska Title V/MCH Director continues to participate as part of the SIG project management team, assuring ongoing coordination with public health initiatives. //2007//

/2010/ Since FY 2006, several developments resulted in additional focus on children's mental health. LB 542 (2007) was created to parallel an emphasis on children and adolescents that LB 1083 (2004) provided for adults and to oversee implementation of the children's behavioral health plan until June 30, 2010. LB 542 (2007) created the Children's Behavioral Health Task Force, which was charged with preparing a children's behavioral health plan by December 4, 2007. The Children's Behavioral Health Task Force developed 16 recommendations designed to improve Nebraska's child and adolescent behavioral health system. The scope of the plan includes:
1. The development of a statewide integrated system of care to provide appropriate educational, behavioral health, substance abuse, and support services to youth and their families serving both adjudicated and non-adjudicated youth; 2. The development of community-based inpatient and subacute substance abuse and behavioral health services and the allocation of funding for such services; 3. Strategies for effectively serving juveniles assessed in need of substance abuse or behavioral health services upon release from the Youth Rehabilitation and Treatment Centers; 4. Development of needed capacity for the provision of community-based substance abuse and behavioral health services for youth; 5.Strategies and mechanisms for the integration of federal, state, local, and other funding sources for the provision of community-based substance abuse and behavioral health services; 6. Measurable benchmarks and timelines for the development of a more comprehensive and integrated system of substance abuse and behavioral health services for youth; 7. Identification of necessary and appropriate statutory changes for consideration by the Legislature; and 8.
Development of a plan for a data and information system for all youth receiving substance abuse and behavioral health services. LB 542 also required that, "The department shall provide a written implementation and appropriations plan for the children's behavioral health plan to the Governor and the committee by January 4, 2008." That response was prepared, and the Division of Behavioral Health continues to work on the plan through a newly created Children's Behavioral Health Unit.

Then, Legislative Bill 157 was introduced in the 2008 Legislative Session. Forty-eight senators voted for the final version of LB 157. It was signed by Governor Heineman on February 13, 2008. This Safe Haven law did not provide an age limit for which a person would drop off a child at a hospital and not be prosecuted. The full text of LB 157 reads: "No person shall be prosecuted for any crime based solely upon the act of leaving a child in the custody of an employee on duty at a hospital licensed by the State of Nebraska. The

hospital shall promptly contact appropriate authorities to take custody of the child." The law went into effect on July 18, 2008. In September, families began leaving children at Nebraska hospitals, all of these children were over age 1 and several were older than age 10. A special session of the Legislature was called in November, and LB 1 was introduced, passed and signed into law effective November 21. LB 1 limited the age of a child under the Safe Haven provisions to be 30 days old or younger. During the less than 6 months that LB 157 was in effect, 36 children were dropped off at Nebraska hospitals, many with complex behavioral health needs, bringing signficant public attention to the mental health needs of children and youth and the systems that were to meet those needs.

During the 2009 session, the Legislature considered many options for addressing unmet children's behavioral health needs. On May 22, Gov. Dave Heineman signed LB 603 into law. The bill provides additional services, support and professional resources to help Nebraska families dealing with children's behavioral health issues.
The bill helps address the gap in services for children with behavioral health issues by providing services and expertise to support children and their families. The bill includes: 1) A statewide hotline for families facing a behavioral health crisis available 24/7 and staffed by professionals trained in mental health assessment; 2)
A family navigator program to provide follow-up assistance and one-on-one support to families contacting the crisis hotline. Family navigators will have the experience and training to help a family access mental health services, and offer assistance to parents and guardians who may not be familiar with providers in Nebraska's behavioral health network; and 3) New services for families that adopt or serve as guardians of a child with behavioral health challenges. Case management and post-adoption services will be available on a voluntary basis. Roughly half the of the children and teens involved in 2008 safe haven cases in Nebraska had been adopted or placed in a guardianship with a relative. Studies show continuing services is effective in helping families through the transition and ensure a child's placement is a permanent.

LB 603 also took a step toward expanding services and helping more families access help by increasing the eligibility level for the State Children's Health Insurance Program (SCHIP) from 185 to 200 percent of the federal poverty level. It also adds secure residential treatment to the list of Medicaid-eligible services in Nebraska. It also provides an additional $1.5 million in the next biennium to Nebraska's six behavioral health regions to expand an existing mentoring program and support other services for children. Finally, the bill seeks to encourage greater professional support in Nebraska communities. It establishes the Behavioral Health Workforce Education Center at the University of Nebraska Medical Center (UNMC). The center will recruit and train more psychiatry residents and develop six behavioral health training sites across the state.

Then, in the spring of 2009, the H1N1 outbreak brought to light a number of issues, needs and challenges related to preparedness. Lifespan Health Services staff and the Title V/MCH Director participated in the emergency response. Experiences during this outbreak have lead to more specific planning regarding the role of various professionals across the Division, how we prepare for the needs of specific populations, including MCH and CSHCHNpopulation, and how operations are managed during an event such as an outbreak. //2010//

Medicaid reform is the priority for HHS Home and Community Services Division (now Division of Medicaid and Long Term Care). Nebraska has initiated Medicaid reform efforts in order to assess the current program and plan for the future. Legislation was passed (LB 709) that established the requirements for a Medicaid reform plan. This law requires that a plan be developed by December 1, 2005. As required by the law, the Governor and the chairperson of the Health and Human Services Committee have each designated a person to be responsible for the development of the plan. The Governor's designee is the Director of Health and Human Services Finance and Support; the Legislature's designee is the General Counsel of the Nebraska

Legislature's Health and Human Services Committee. A Governor-appointed 10-person council will advise the process, and the Health and Human Services System will provide the staffing. The Title V/CSHCN Director is chairing a work team (Disabled Adults) and the Title V/MCH Director is a member of another work team (Children and Pregnant Women).

//2007/ As required by LB 790, the Nebraska Medicaid Reform Plan was presented to the Governor and the Legislature on December 1, 2005. This plan included a wide range of findings, recommendations and strategies. The plan made it clear that no major changes in eligibility or benefits were being recommended at this time. The recommendations of most significance to the MCH and CSHCN populations were: establishing a separate SCHIP program (currently a Medicaid expansion); requiring a contribution from parents with incomes in excess of 150% of poverty for children participating in the Katie Beckett program, Aged and Disabled Waiver program, Children's Developmental Disability Waiver, the Early Intervention Waiver, and the State Ward Program; and including as a covered services, a nurse home visitation program for high-risk pregnant teens. Other recommendations, such as those related to prescription drugs, will have impacts as well, if/when implemented. Work groups are currently studying these recommendations in greater detail. //2007//

/2008/ Understanding the situation states everywhere are facing with regards to providing services to low income individuals, Nebraska Health & Human Services has chosen Medicaid reform as the state's priority. A work group for children with special health care needs was developed to research methods to reduce the cost of providing services to this particular population. The results of this work group became a component of the Nebraska's Medicaid Reform Plan, which was published on December 1, 2005. Work groups were formed to examine the most appropriate methods of implementing each component of the reform plan. //2008//

/2009/ The intiatives of Medicaid reform are being revisited with plans to implement various components. The priorities of the current administration are the standardization of services statewide, transparency and accountability of our programs, and longterm the sustainability of Medicaid. The Medicaid Reform Plan proposed twenty-six initiatives intended to focus the program on its core mission to provide medical assistance for truly needy Nebraskans in a manner that promotes access to appropriate services, fosters the development and utilization of less intensive care, encourages consumer responsibility and Medicaid alternatives, and expends limited resources prudently. Several of the initiatives target management of prescribed drugs, as the fastest growing expenditure category, and long-term care services, as the largest expenditure category. Other initiatives emphasize the involvement of the consumer in appropriate health care utilization, the development of alternatives to Medicaid-financed care, and the alignment of program growth with available resources. Service limitations resulting from Medicaid Reform are generally being applied to Medicaid-eligible adults and should not directly impact the CSHCN population.

Initiatives of particular interest to the Children with Special Health Care Needs population include the identification of cost-effective telehealth technologies, the expansion of home and community-based services, and the development of a premium buy-in program for children with disabilities. A sliding fee schedule for premiums, based on family income, is expected to be piloted under the Medicaid Home and Community-Based Waiver for families with children with Autism Spectrum Disorder. Projected implementation is January 1, 2009. //2009//

3. Process used to determine the importance, magnitude, value, and priority of competing factors upon the environment of health services in the State.

Section II, Needs Assessment, provides a comprehensive description of the processes used to determine Nebraska's MCH/CSHCN priorities. In addition, the Lifespan Health Services Unit continues to draw upon the recommendations of a consultant that assisted the Department in 2001 in determining strategies for investment of Title V/MCH Block Grant Funds. This

consultation was an important step in developing the framework for external allocation of Block Grant funds for the period beginning FFY 2003. This framework considered a variety of factors, including the availability of tobacco settlement funds to support local health departments and a concurrent need to support Tribal MCH efforts as part of a government-to-government relationship. This framework is being modified somewhat, but in essence remained intact for external allocation of funds for FFY 2006 -- 2008.

In addition to these formal processes, the Lifespan Health Services Unit has negotiated the demands of competing environmental factors by maintaining a focus on building its capacity to carry out the 10 essential public health services, both at the state level and at the community level. With flat or diminishing financial resources, it is clear that the Office and Title V cannot be all things for all people, nor can it pay for an extensive array of services. Rather, it is in our best interest to build public health capacity, and be aggressive in developing and maintaining a wide range of public health partnerships.

In this vein, the Lifespan Health Services Unit completed an abbreviated version of the CAST-5 assessment in FFY 2005 (see Section II). During June 2005, the Office also participated in the application of the State Public Health Performance Standards. This latter activity will yield a state public health strategic plan, which in conjunction with our CAST-5 assessment, will provide the blue print for building capacity over the next few years. As a parallel activity, the framework for external allocation of Title V funds continues to include awards to local health districts for the development/enhancement of capacity to carry out the essential services as they relate to the MCH population.

/2007/ Additional activities were carried out during FY 2006 related to infrastructure building. The Title V/MCH Director is participating in the development of an updated public health strategic plan, and is part of a group identifying optimal roles and working relationships between state public health and the local health districts. //2007//

/2010/ The Nebraska Public Health Improvement Plan, referenced above, was finalized, approved, and published in SFY 2009. The plan is a blueprint for improving the public health system in Nebraska. The purpose of this strategic plan is to identify a new vision for public health in Nebraska and the resources that are necessary to achieve the vision. Seven major strategic directions are identified. The seven major strategies in this plan were developed by the Turning Point Public Health Stakeholders Group. This plan is intended as a guide for public health leaders, as well as state and local policymakers as they continue to strengthen and shape the public health system.

At the turn of the 21st century, when the first public health improvement plan was developed, stakeholders saw the public health system in Nebraska to be weak, fragmented, and severely underfunded. Public health services and programs were available in less than one-quarter of the counties in the state. By 2006, a major transformation had occurred. Local public health departments now cover every county and provide all of the core public health functions. The new public health infrastructure has strong leaders, exciting new partnerships, and improved funding. Despite this success, many challenges still need to be addressed. For example, the public health workforce still needs training and education in many of the core competencies. Also, new resources and leadership are needed to build integrated data systems that are more accessible to researchers and public health practitioners. There are also many complex problems that can only be resolved through effective collaborative partnerships. Some of these problems include access to health care services, disparities in health status between the white population and racial and ethnic minority populations, the inadequate supply of health professionals in rural areas, the dramatic increase in the number of people that are overweight and obese, the emergence of new diseases such as SARS and West Nile Virus, and the threat of pandemic flu. To meet these challenges, the public health infrastructure will need to be strengthened and become more efficient. There is also

a need to demonstrate accountability to both policymakers and the general public through the use of a more business-like model to determine the feasibility of service expansion. Finally, public health leaders must
continue to build collaborative partnerships with the medical community, businesses, schools, and many others. Through these diverse partnerships, appropriate strategies can be developed and sufficient resources can be found to achieve the vision of healthy and productive individuals, families, and communities across Nebraska.

This planning document, found at http://www.dhhs.ne.gov/puh/oph/ will be an important guide and influence on Title V/MCH and CSHCN planning as we move into the next decade. //2010//

/2009/ Lifespan Health Services completed an environmental scan of planning and capacity building related to the ten MCH/CSHCN priorities. Noting that planning and infrastructure development was being carried out by public health and human service partners for a number of these priorities, focused strategy development was carried out for three priorities (Preterm birth/LBW, Overweight women/children, and Transition Services for CSHCN). See Section IV. Priorities, Performance and Program Activities for more detail.//2009//

/2010/ The strategies developed for the three priorities as described above (preterm birth/LBW, overweight women/children, and transition services for CSHCN) largely guided funding decisions for community based projects for the 3 year period of FFY 2009 through FFY 2011. Again, see Section IV. In FFY 2009, a similar strategy development process was launched for the priority issue of infant mortality disparities. The work group has been meeting since March 2009, with a target of fall 2009 for developing logic models to guide the work of the Department, Division, and Unit in addressing infant mortality disparities.

Strategic planning at the Unit level was completed in FY 2009 for Lifespan Health Services. This planning included not only staff involved with Title V funded activities, but all other programs and projects (such as WIC, CSFP, Immunizations, Breast and Cervical Cancer Screening, and Title X/Family Planning). This planning process yielded a mission and vision statement and the identification of 11 core functions that cross over all programs and initiatives. The 60+ staff in the Unit selected "Partnership/Collaboration Building" for strategic development during FY 2010. Educational and skill building activities will start yet this summer. //2010//

4. Characteristics presenting a challenge to delivery of Title V services

Details are provided earlier in this section regarding a wide range of issues, including large geographic area, urban and rural differences, increasing diversity, racial and ethnic health disparities, an aging population, and special populations. These issues are ongoing challenges to the delivery of health and human services to Nebraska's MCH and CSHCN populations.

In recent years, Medicaid eligibility changes have been made in response to state budget shortfalls. As a consequence, thousands of low income children and parents no longer have Medicaid coverage. These reductions in coverage have and will continue to stress Block Grant funded services, particularly the Medically Handicapped Children's Program, which has long been a gap filler for those children not eligible under Medicaid. In addition, both federal and Nebraska lawmakers have expressed intent to further examine ways to reduce and/or control Medicaid expenditures. Nebraska's Medicaid reform act requires that a plan be developed by December 1, 2005. /2007/ As previously stated, this plan did not make major changes to eligibility or benefits, except for the recommendations for a separate SCHIP program and for contributions from parents for children served through certain waiver programs. Operational plans for these recommendations are still pending. //2007//
/2010/ LB 603 signed into law in 2009 increases the income eligibility for children under

Nebraska's SCHIP to 200% of the federal poverty level. SCHIP is a Medicaid expansion in Nebraska. The income eligibility for pregnant women remains at 185% of the federal poverty level.//2010//

Health professional shortages have been a longstanding challenge for delivering MCH services across the state. Thirty-four of 93 counties are considered all or partially included in a Health Professional Shortage Area. The number of Federally Qualified Health Centers (FQHCs) has grown to 9, but these centers do not begin to address the vast distances some families have to travel to receive care.

Historically, Nebraska has been challenged in meeting match requirements for the Title V/MCH Block Grant at the state level, resulting in a significant dependence on local match sources. This situation will likely become more acute over time, as state general funds become scarcer and tobacco settlement funds are further diverted to other uses. At the same time, local match has usually included considerable amounts of Medicaid reimbursement as match. With fewer children now eligible for the program, that income will be reduced and thus negatively impacting local match (as well as the obvious disadvantage to children at risk). These compounding factors, though not a crisis this year, may become so in the future.

A more recent issue receiving attention in Nebraska and elsewhere is the aging of the public health work force. Success in carrying out the 10 essential public health services is dependent on an adequately trained work force. As many state and community level public health professionals retire in the next few years, the recruitment and retention of new public health workers is a concern. The relatively new MPH program, offered jointly by the University of Nebraska Omaha and the University of Nebraska Medical Center, addresses this need, in part. Non-competitive compensation and limited job advancement opportunities will continue to be a deterrent to recruiting new public health professionals, especially within state government.

/2010/ The full impact on public health programs of LB 403 is yet to be determined. This bill, passed and signed into law in April, goes into effect October 1, 2009. LB 403 requires the verification of lawful presence in the United States for the receipt of public benefits. It clearly exempts emergency health care, testing and treatment of communicable diseases, immunizations, and certain short term disastor or public safety services from these verification requirements. The agency is still examining the implementation issues related to programs such as WIC, CSFP, Title X Family Planning, and Title V funded community based services.//2010//

In summary, Nebraska's greatest challenges in providing MCH/CSHCN services are: widely and unevenly dispersed populations; increasingly diverse populations; significant health disparities among racial/ethnic minorities; shortages of health professionals primarily in rural areas; diminished financial resources; and an aging public health workforce. ***/2010/ LB 403 may have an impact on service provisions to certain MCH populations//2010//***

B. Agency Capacity

With Title V/MCH Block Grant funding remaining flat and inflation increasing costs of doing business, maintenance of agency capacity to promote the health of all mothers and children, including CSHCN, has become increasingly challenging. As indicated in the previous section, investments in infrastructure and collaborative partnerships continue to be emphasized as the most efficient means for investing the Block Grant as a means of sustaining capacity.

Community level agencies have traditionally provided a number of services that encompass all levels of the public health pyramid. For the MCH population, services have included: home visitation; prenatal care; support services to at-risk pregnant women (particularly teens) and

families with infants and children; "safety net" primary and preventive care services to children; and needs assessment and outreach activities for minority and newly arrived ethnic populations. For FFY 2006, $1.2 million in Block Grant funds are being made available for community level projects. Competitive applications were received July 1, 2005, with awards to be made by or about August 15, 2005. It is anticipated that these awards will be primarily for direct, enabling and population based services for pregnant women, infants, children, and CSHCN.

/2007/ During FY 2006, 8 agencies were competitively awarded subgrants of Title V/MCH Block Grant funds to provide a wide range of community based services. Most of the funded projects are enabling and population based services, with some direct services provided to special populations. Two of these projects provide enabling services to CSHCN. Together, these 8 projects represent a smaller group of community based services funded through the Block Grant compared to prior years. This reflects both a shift to infrastructure building being accomplished through contracts with local health districts, and a growing proportion of the funds needed to support state level infrastructure. //2007//

/2009/ In May 2008, a Request for Applications (RFA) was issued for community-level MCH projects, with applications to be submitted by July 1, 2008. Those applications are currently being reviewed, with awards to be made for an approximate total of $1,000,000. This amount for community-level projects is less than the previous 3-year funding cycle, demonstrating the increasing demand upon the Title V/MCH Block Grant for the support of state level MCH and CSHCN infrastructure and services.//2009//

/2010/ The purpose of the RFA issued in May 2008 was to focus Title V/MCH Block Grant funding at the community-level on a selected set of priority needs to concentrate efforts and maximize outcomes. Applicants were to address one and preferably no more than three of the following public health goals and one and preferably no more than three outcomes associated with each selected goal:

PERINATAL RELATED GOALS- Reduce rates of preterm and low birth weight births; Reduce rates of infant mortality; and Eliminate disparities among racial/ethnic minorities for preterm and low birth weight, SIDS and other sudden unexpected infant deaths, and/or infant mortality. ASSOCIATED PERINATAL OUTCOMES- Increased access to preventive health care for women of reproductive age; Health care systems provide culturally competent preconception health care; Woman at risk for or with history of poor birth outcomes receive targeted pre and interconception care; Women have access to supportive networks within communities (i.e. family, faith, business/workplace, education, peer networks) to decrease stress and isolation; Women of reproductive age have improved access to mental health services; Women demonstrate a reduction in adverse health behaviors and an increase in healthy behaviors; Women/couples have a reproductive life plan; More women/couples have pre-pregnancy health visits; Women/couples have improved health literacy as measured by their ability to understand and act on information and navigate the health system; Health and human service providers deliver consistent, accurate messages on safe sleep practices for infants; and Parents and other caregivers routinely provide safe sleeping environments for infants.

HEALTHY WEIGHT RELATED GOALS - Women of reproductive age are at a healthy weight, including prior to and between pregnancies; and Children enter kindergarten at a healthy weight. HEALTHY WEIGHT ASSOCIATED OUTCOMES - Health care providers use evidence-based guidelines and best/promising practices in helping women achieve and maintain a healthy weight; Communities and health care systems have increased capacity to provide services to promote healthy weight among women and children; More workplaces and schools will have effective wellness policies that address: nutrition and physical activity; breastfeeding support; and environmental supports for wellness; More women in school and/or workplace settings engage in healthy behaviors; and Communities, through governing bodies and community leadership, adopt plans and

policies to increase access to healthy foods and physical activity.

Applicants were to consider and incorporate as appropriate the following themes: 1. An emphasis on population-based, primary prevention and wellness models; 2. Social ecological model, including social determinants of health and health equity; 3. A life course approach to improving health outcomes, including the importance of preconception and interconception health; and 4.Importance of community-wide and system level change

Through this competitive process, the following community-level projects were approved for the 3-year funding cycle that ends September 30, 2011.

Four Corners Health Department (Butler, Polk, Seward & York counties) - Partner with communities to promote healthy weight among children. Implement Animal Trackers curriculum in daycares/preschools. Animal Trackers increases structured physical activity time during the preschool day. Host Family Fun Nights to support families in physical activity and healthy eating. Enhance current activities, e.g. Concordia University's Early Childhood Education Conference, and Seward Family Fun Night. Contract with Registered Dietitian to reach families through farmers' markets and immunization clinic.

Northeast NE Family Services (Fremont) - Reduce the incidence of low birth weight and preterm births.
Enhance family planning visits to include preconception risk assessment and reproductive health plan. Increase access to early prenatal care via Three Rivers District Health Department's Call Care Line and referral to physicians.

Goldenrod Hills Community Action, Inc. (Burt, Cuming, Dodge, Madison, Pierce & Stanton counties) - Enhance pre-existing Operation Great Start, which is non-intensive case management and home visitation services provided to low and medium risk clients for infants up to 12 weeks of age with a focus on first-time mothers. Program provides an array of supports for parents to be successful. Referral sources are Faith Regional Health Services and St. Francis Memorial Hospital and clinics, and Goldenrod Hills WIC and immunization programs. Provide teen parent education to pregnant and postpartum teens in Norfolk Public Schools. Preconception and interconception care offered to females receiving HPV immunizations.

Panhandle Public Health District (the 11 counties of the Panhandle region) - Campaign for and support workplace policy change and environmental supports for breastfeeding, physical activity and nutrition. Partner with clinics to assess reproductive women for preconception / interconception plan followed by a brief intervention at regular clinic visits.

South Heartland District Health Department (Adams, Clay, Nuckolls & Webster counties) - Assess, train, and support workplaces to develop teams to implement worksite wellness policy and supports in 20 small businesses. More workplaces and schools will have effective wellness policies that address nutrition and physical activity, breastfeeding support, and environmental supports for wellness. The local health department's partners with Mary Lanning Memorial Hospital business health department, Well Workforce Nebraska, and Educational Service Unit #9.

Lincoln Lancaster County Health Department (Lincoln) - Implement "A Family Approach to Prevention of Childhood Obesity" in three census tracts of Lincoln with a 34% minority population, > 25% of population is < 18 years of age, and with a high rate of poverty. Convene community partners and resources to pilot "54321 GO" project (participants focus on achieving 5 servings of fruits and vegetables, 4 servings of water, 3 servings, of

low-fat dairy products, 2 hours or less of screen time, and 1 hour or more of physical activity each day) and evaluate effectiveness of this approach.

Central Health Center (Grand Island, Kearney, and Lexington) - Reduce the incidence of low birth weight and preterm births. Integrate preconception and interconception care into family planning clinic visits, develop reproductive life plans. Use information technology (My Space) to promote.

University of Nebraska Medical Center, Maternal Care Program (Omaha) - Expand scope of pre-existing Maternal Care Program that provides prenatal care to include pre- and interconception care. Add training and continuing education for medical students, residents, and practicing physicians on life course concept to improve birth outcomes. Actively engage local providers in Omaha who provide health care to at-risk women, e.g. Charles Drew Health Center, One World Community Health Center, and the Fred LeRoy Health and Wellness Center.

Northeast Nebraska Public Health Department (Cedar, Dixon, Thurston, Wayne counties) - Create Northeast Nebraska Child-Fetal Infant Mortality Review Project with a Case Review Team and Community Action Team to perform death case reviews with participation from Omaha and Winnebago Tribes. Evaluate home visitation services in the district. Formation of Health Literacy Council.//2010//

A separate Tribal set aside of $200,000 has been established for the four federally recognized Tribes headquartered in Nebraska. These funds may be used for either services or for infrastructure building. Then, to assure continued investment in community-level MCH infrastructure, $300,972 has been set aside for contracts with Nebraska's local health districts as recognized under NE LB 692.

/2009/ For the upcoming 3-year funding cycle, beginning October 1, 2008, the Tribal set aside is reduced to $150,000 per year. The set aside for local health district contracts for MCH infrastructure building has been discontinued. These two actions, along with the reduced amount of funds available for competitively selected community level projects, further demonstrates the diminishing purchasing power of the Block Grant.//2009//

/2010/ The Tribal set aside was continued at $200,000 per year during FY 2009.//2010//

State level programs receiving Title V/MCH funds that assure preventive and primary care services to pregnant women, mothers, infants, and children include the state's Perinatal, Child, and Adolescent Health including school health, the MCH Epidemiology Unit (which includes the Child Death Review and PRAMS); Newborn Screening and Genetics; Office of Minority Health; Office of Women's Health; Dental Health; and Reproductive Health. In addition, the Block Grant provides partial support to the Birth Defects Registry.

Additional sources of revenue are continually being pursued to supplement state level MCH activities. Recent awards include a perinatal depression grant and a new newborn hearing screening grant. An allocation of TANF funds for home visitation ($200,000 year for 2 years) has also recently become available, providing a new source of funds for MCH services.

/2008/ The Perinatal Depression grant, referenced above, has expired, though work products developed with these grant funds will be supported and promoted in collaboration with partners. The TANF allocation for home visitation has also expired at the end of State FY 2007 (June 30, 2007), but a new apppropriation of $600,000 of state general funds per year for two years was included in the Department's funding for the 2008 - 2009 biennium. The Office of Family Health will be collaborating with the Office of Protection and Safety in administering this expanded resource for home visitation. These efforts will include coordinating efforts with Medicaid, Head Start, and the Child Abuse Prevention Fund Board in making optimal investments in evidence-

based home visitation.//2008//

/2010/ Late in FFY 2009, Nebraska was awarded a First Time Motherhood/New Parents Initiative grant. Nebraska's project is titled "Building Bridges - For You, For Now, For Life," and the project period is September 1, 2008 through September 30, 2010. Its goals are to: Increase awareness among women, ages 16-25, of the benefits of a life-course approach to pre- and interconception health; and Increase awareness among community-based providers of the benefits of a life-course approach to pre- and interconception health and how to incorporate in various settings. The target audience is Nebraska women 16 -- 25 years (Millennials) who are low income and at risk of being uninsured or underinsured. Messages will be tailored for urban/rural, African American, Hispanic, and Native American women, and husbands/partners. Key activities include: YEAR ONE - A contractor is selected through a competitive process;The contractor will use a social marketing model to develop and test a range of messages related to a life-course perspective and pre and interconception health based on CDC's model; The subject matter and modes of delivery will be determined through focus groups and other methods; The effectiveness of the Healthy Mothers, Healthy Babies Helpline will also be tested with Millennials;
Results of focus groups and other tested messages will be used to develop a life-course health campaign targeting young women; and A second contractor will be selected to develop outreach and training to health, human services, educational providers, and faith-based providers, then deliver this training. YEAR TWO - Public awareness messages targeted to at-risk young women and men will be launched;The second contractor from Year One will complete development of training modules and tool kits for providers, and initiate statewide events; and Community-based organizations are competitively selected for subgrants to develop modifications needed to incorporate new and expanded messaging within their settings, and begin creating systems supporting a life-course approach to health, including pre- and interconception health.

Public input provided during preparation of this application and annual report addressed the need to build capacity in a number of areas: more consistent communication network; infrastrucure opportunities for community initiatives to implement programming developed by the State-level Title V; and the provision of techical assistance, and when feasible, financial assistance to support local initiatives. Comments also included recommendations to work more closely with local public health organizations in building local capacity. Interim activities addressing these comments will be explored during 2010, as the 5-year comprehensive needs assessment will look at these issues in greater depth.//2010//

For CSHCN, one state-level program provides the majority of Title V-funded services to CSHCN -- the Medically Handicapped Children's Program (MHCP). Located in Medicaid Long Term Care, Safety and Independence Supports Unit, MHCP provides or pays for specialty and sub-specialty services through agency and contracted staff from a number of hospitals and private practitioners throughout the state. Many of these professionals participate in community-based multi-disciplinary team diagnostic and treatment planning clinic sessions, and they also offer medical care and follow-up medical services. Community-based medical home family physicians and pediatricians also provide follow-up services and care coordination throughout Nebraska.

In addition, MHCP operates the Disabled Children's Program (DCP) for those children eligible for SSI. The Disabled Children's Program (DCP), which is a component of MHCP, provides funding to help families care for their children with disabilities at home. A family focused assessment process determines the need for services. Some of the funded services include: respite care; mileage, meals and lodging for long-distance medical trips; special equipment and home/architectural modifications; and care of siblings while care is received by the child with a disability/special need. The Disabled Children's Program (DCP) was designed to serve children who have a special health care need, receive monthly Supplemental Service Income (SSI)

checks, are 15 years of age or younger, and live at home with their families.

/2009/As the Center for Medicare and Medicaid Services grant, EPSDT Portals to Adulthood, comes to an end, we will implement a transition clinic (consultation) as designed by this grant. The transition clinics will be targeted to CYSHCN seventeen to twenty-one to assist them in knowledge of how to move into adulthood and mange their special health care needs and adult services. The clinics/consultation will examine medical, educational, employment, housing, and all life planning aspects of becoming an adult with special health care needs.//2009//

In Nebraska, statutes pertaining to maternal and child health are found in Chapter 71, sections 2201-2208. The duties concerning the responsibility of the Nebraska Health and Human Services as to the federal early intervention program are found in 43-2509. Statutes requiring the birth defects registry are found in 71-645 through 648. Metabolic screening and associated responsibilities are found in 71-519 through 71- 524. Finally, CSFP is found at 71-2226 and WIC at 71-2227.

In 2003, LB 407 was signed into law which allocated $1,620,000 in tobacco settlement funds to the Lifespan Respite Services program for the biennium from July 1, 2003 through June 30, 2005. Use of this source of funds for respite care has allowed expansion of this service and has resulted in more MHCP funds being devoted to medical and rehabilitative services.

/2007/ Nebraska continues to strive to promote and support culturally competent approaches to service delivery. Data collection and analysis, whenever possible, addresses race and ethnicity, and to a lesser degree, language. For instance, Nebraska stratifies its PRAMS data by race and ethnicity, and has obtained CDC approval to include Nebraska Native American women who deliver outside of Nebraska in its sample, to assure that these women are adequately represented in data collection. Nebraska MCH/CSHCN programs benefit from the efforts of other offices in HHSS to collect culturally relevant data, such as the Minority Behavioral Risk Factor Survey. During the comprehensive needs assessment completed in 2005, analysis by cultural groups was extensively done and disparities among groups was one of the criteria used in prioritizing needs.

HHSS has a long history of offering and promoting training in cultural competency for both its staff and stakeholders. It established an Office of Equity and Diversity which sponsors training and events for HHSS employees. Culture and language are frequently incorporated into the wide range of training and technical assistance activities sponsored by the Office of Family Health for its community partners. The Office of Family Health has a strong working relationship with the Office of Minority Health and has collaborated on training events tailored for specific audiences. In addition, that office sponsors each year the Minority Health Conference which is an outstanding event featuring national speakers and draws attendees from across the state.

Collaborations with community leaders and groups are integral to participatory government. The Nebraska Minority Public Health Association is a key stakeholder and partner, with its members participating in and contributing to needs assessments and major initiatives over the years, including the 2005 needs assessment. The Office of Family Health has ongoing working relationships with Northern Plains Healthy Start and Aberdeen Area Tribal Health Directors' programs, and works closely with the Native American Liaison in the Office of Minority Health. Individual programs work with specific communities and community leaders in developing culturally relevant initiatives, such as the Abstinence Education Program's Latino events in 2005 and Native American focused activities in the Panhandle in 2006.

Since FY 2003, the Office of Family Health maintains a set-aside of Title V funds for those federally recognized Tribes headquartered in Nebraska. This set-aside recognizes the special government-to-government relationship between HHSS and the Tribes, as well as a priority to meet the health needs of the Native American MCH populations. In allocating funds for other community based programs, the needs of culturally diverse groups are directly addressed in the

RFPs, through expectations for addressing the needs of racial and ethnic minorities and engaging representatives from culturally diverse groups in program planning and development. Further, the criteria for funding decisions includes a consideration of relative need among geographic areas, including needs specific to racial and ethnic groups.

Further, the CLAS standards are an expectation outlined in the Title V RFP for communities and these standards are thus incorporated by reference into the awards made to community subgrantees. //2007//

C. Organizational Structure

/2010/ Several changes in the Department's structure have occurred over the past five years. The cumulative narrative provided in Nebraska's annual report and application since FFY 2005 has been deleted, and a summary of the current organizational structure is being provided for the FFY 2008 report/FFY 2010 application.

During the 2007 legislative session, LB 296 was passed and signed into law by the Governor. This bill regorganized the three agencies that formerly formed the Health and Human Services System into one agency: the Department of Health and Human Services. This new structure went into effect July 1, 2007. The single agency is headed by a Chief Executive Officer. The Department has six divisions: Public Health, Behavioral Health, Children and Family Services, Developmental Disabilities, Medicaid and Long Term Care, and Veterans Homes. Title V/MCH functions are located in the Division of Public Health. Title V/CSHCN functions are within the Division of Medicaid and Longterm Care, Safety and Independence Supports Unit. Reorganization also occured within the Division of Public Health, including the combination of the Office of Family Health and the Office of Women's Health, forming Lifespan Health Services. Throughout this application, references to the former Health and Human Services System and the three former agencies in the system have been replaced with the current agency name, DHHS. References to the Office of Family Health have been changed to Lifespan Health Services Unit.//2010//

/2008/The Lifespan Health Services Unit, Division of Public Health, provides the principle oversight for administration of the Title V/MCH Block Grant. The Planning and Support Unit reports to the Administrator for the Unit who is also the Title V/MCH Director. The unit includes the Federal Aid Administrator and an Administrative Assistant, for a total of 2.0 FTE. The MCH Planning and Support Unit is responsible for organizing and leading the development of the annual plan and report, administers sub-grants to communities, monitors allocations to other HHSS units and programs, and coordinates Title V funded activities with other public health programs within the Office and agency./2008/ The Office of Family Health has been combined with the Office of Women's Health, forming Lifespan Health Services.//2008//

Other programs and units within Lifespan Health Services include: Commodity Supplemental Food Program; WIC; Immunizations; Newborn Screening and Genetics (including Newborn Hearing Screening); Perinatal, Child and Adolescent Health (including school health, Early Childhood Comprehensive Systems, and Abstinence Education); Reproductive Health; and the MCH Epidemiology (includes PRAMS, Child Death Review, and SSDI-supported activities.)

/2010/Special Services for Children and Adults are administered within the Safety and Independence Supports Unit of the Long-Term Care Section of the Medicaid and Long-Term Care Division. SIS houses the following programs: Medically Handicapped Children's Program (MHCP), Social Services Block Grant for the Aged and Disabled (Title XX), Disabled Persons and Family Support, SSI Disabled Children's Program, Nebraska Resource Referrals System, Genetically Handicapped Persons Program, and Early Intervention and Medicaid in Public Schools Programs. This Unit coordinates with Medicaid State Plan and Home and Community Based Waiver Services for children with

special health care needs. The Early Intervention Waiver ended and EI Waiver clients are now being served by the Home and Community Based Waiver program//2010//

/2009/Vivianne Chaumont, the Director of Medicaid and Long Term Care, administers the following program areas; Medicaid Services, both State Plan and HCBS Waiver Services for all eligible populations; State Unit on Aging, and the Safety and Independence Supports Unit which manages CSHCN programs listed in the above paragraph. Ms. Chaumont is the co-director for Part C of the Individuals with Disabilities Education Act and the Administrator of the Nebraska Part C/Early Intervention Program/Early Development Network. Early Intervention is co-administered with the Nebraska Department of Education. //2009//

Title V -- both MCH Planning and Support and MHCP -- maintain very collaborative relationship with the Medicaid program, Vital Statistics Management Unit, and the Data Management Unit all of which are located in the Department of Health and Human Services. In addition, Title V works with a number of programs throughout DHHS including: child care, juvenile services, mental health and substance abuse, developmental disabilities, minority health, health promotion and disease prevention, communicable diseases, dental health and rural health. Of these areas outside of Lifespan Health Services and Safety and Independence Supports Unit, only minority health, data management, and dental health receive federal Title V funds. An organizational chart displaying the agencies and units is found as an attachment.

Department programs funded by the Federal-State Block Grant Partnership budget are described in the previous section. Community-based and Tribal programs supported by the Block Grant for the period of FFYs 2006 -- 2008 will be determined on or about August 15, 2005.

/2009/Community-based and Tribal programs supported by the Block Grant for the period of FFYs 2009 - 2011 will be determined on or about August 15, 2008.//2009//

/2010/See Section B Agency Capacity for details of the process for and outcome of funding community-based and Tribal programs for the 3-year period that began October 1, 2008.//2010//

/2008/ Nebraska has received a system change grant, Early Periodic Screening and Diagnostic Treatment Portals to Adulthood. This grant establishes protocols and procedures to transition children from pediatric services to adult medical services. The children targeted would be the CSHCN. Current CSHCN clinics, described in a later section, are being used to pilot the transition component. //2008//

An attachment is included in this section.

D. Other MCH Capacity

As described earlier, the MCH Planning and Support Unit within Lifespan Health Services has primary responsibility for the ongoing administration of the Title V/MCH Block grant. /2008/MCH Planning and Support has been re-named Planning and Support within Lifespan Health Services.//2008//

Programmatic activities are carried out by various staff within the Lifespan Health Services. The Perinatal, Child and Adolescent Health Unit is responsible for school health, adolescent health including abstinence education, child health, Healthy Mothers, Healthy Babies toll-free line, perinatal issues such as perinatal depression, and the Early Childhood Comprehensive Systems (ECCS) grant. This unit is staffed by 5.0 full time staff.***/2010/Perinatal, Chld, and Adolescent health manages the First Time Motherhood/New Parents Initiative grant. This project is greatly improving the Unit's capacity to do effective social marketing with young men and women. By 2010, plans are to have social marketing strategies in place using digital and***

other media tested with young women ages 16-25.//2010//

MCH Epidemiology was created in FFY 2004, and includes PRAMS, Child Death Review, and SSDI activities. It is staffed by 3.5 FTE and a 0.75 contract employee.

The Newborn Screening and Genetics Program staff is responsible for the oversight of Nebraska's newborn metabolic screening activities, genetics planning and development, and newborn hearing screening. It is staffed by 5.0 full-time employees and 1.0 temporary employee.

In addition to administering the Title X grant, the Reproductive Health Program carries out a wide range of activities related to women's and adolescent health and is staffed by 3.7 full-time employees.

//2008/ The Reproductive Health Program is now staffed with 3.4 permanent FTE positions.//2008//

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides supplemental food, nutrition and health education, and related services through 14 local agencies across the state. The program currently serves over 40,000 participants each month. WIC has provided leadership in MCH nutrition activities, including breastfeeding promotion and support. The State WIC Director is Nebraska's representative to the Association of State and Territorial Public Health Nutrition Directors (ASTPHN). The program is staffed by 9 full-time FTEs, with an additional 2 information technology FTE permanently assigned to the program. The Commodity Supplemental Food Program serves an additional 14,000 individuals each month, the majority being seniors. This program is staffed by 1 full time FTE.

Also administered within the Lifespan Health Services, the Immunization Program manages CDC 317 and Vaccine for Children funds, and oversees public immunization clinics and the registry supporting these clinics. The program is staffed by 6.25 full time FTEs and a 1 temporary FTE.

/2007/ The Immunization Program now has 7.25 permanent FTEs. //2007// /2008/The Immunization Program is now a part of Lifespan Health Services.//2008//

/2010/Additional capacity may be developed over a 5 year period beginning September 2009. The Lifespan Health Services Unit applied for funds under the Project LAUNCH initiative, through SAMHSA. State level activities, if funded, would further build capacity to support comprehensive young child wellness systems across the state. The local partner for this project is the Boys Town Institute for Child Health Improvement, which would oversee evidence-based early childhood service and system development in the Omaha area.//2010//

The Lifespan Health Services Administrator participates in a wide range of collaborative activities and initiatives described elsewhere. She is supported by a 1.0 Administrative Assistant and 0.2 FTE staff assistant. Paula Eurek, BS, RD, Title V/MCH Director, has been an employee of Nebraska Health and Human Services for 21 years. Her maternal and child health experience includes two years of community-level experience as a WIC nutritionist and over 10 years as a state-level WIC nutritionist and administrator. Ms. Eurek assumed the roles of Administrator for what was the Family Health Services Section and Title V/MCH Director in December, 1995. She had prior experience as the interim MCH Division administrator in 1988-1989. She is currently the Project Director for Nebraska's Integrated Comprehensive Women's Health Services in MCH Programs grant project, and provides general oversight to Nebraska's ECCS grant project and newly awarded perinatal depression grant.

/2010/ No longer a registered dietitian (RD), Ms. Eurek will observe 26 years with the State of Nebraska in September 2009. //2010//

In addition to administering MHCP, the Home and Community Based Services for Aging and Physically Disabled is responsible for a number of CSHCN services and activities. It partially funds the Answers4Families website which includes comprehensive information for families of children with special needs, school nurses, foster and adoptive families, and families, agencies and others concerned with children's mental health. The website hosts discussion listservs (discussion groups for these populations). As well as information and Internet listservs for other populations with special needs. Nebraska Resource Referral System (NRRS), which includes over 8,000 social services type resources including child care, respite coordinator information, medical/health and public health information, food pantries, is accessible through this web portal. Addresses: http://www.answers4families.org and http://www.answers4families.org/nrrs/.

/2009/ The MHCP clinic list and addresses of local workers are available on Answers4Families. Address: http://www.hhs.state.ne.us/hcs/programs/MHCP.htm.//2009//***//2010/ The Answers4Families site will include a list of clinic staff and a short bio of background information to provide families looking at clinic services; information on the medical providers their child would receive services from.//2010//***

The Home and Community based Services for Aged and Physically Disabled is a Co-Lead for Part C of the Individuals with Disabilities Education Act along with the Nebraska Department of Education, Special Populations. Consequently, the Family Partner full time position represents families for both the Early Development Network programs and the CSHCN programs. The Family Partner attends CSHCN training for CSHCN staff, national MCH/CSHCN meetings and is a member of advisory groups to the CSHCN Program. The CSHCN Nurse Consultant staff member has been a family member of a CSHCN in the past but this currently is not the situation.

/2009/Development Tips is tracking Infant Progress statewide in Nebraska started in 2000. The program provides specialized development follow-up for babies who have been in the Neonatal Intensive Care Unit. The Development TIPS program has two main goals: To provide a standard system of developmental follow-up for all infants who have had an NICU experience in Nebraska and to gather information about how babies who have been in the NICU grow and develop, so we can learn how to better meet their unique needs in the future. EDN Services Coordinators are partners with 10 departments/programs to direct referrals to the appropriate service.

In 2007, two additional partners where added to the list of partners (Bryan LGH and Alegant Lakeside in Omaha). Developmental TIPS also plans to begin data collection for the next three years on children that were part of the program who are now entering first grade. //2009//

/2009/ Ginger Goomis, MBA, Title V/CSHCN Director, has been an employee of the State of Nebraska for 34 years. She is currently the administrator of long-term care programs in the Medicaid and Long-Term Care Division of the Nebraska Department of Health and Human Services; areas of responsibility include Medicaid State Plan, and Home and Community --Based Services for long term and chronic care, State Unit on Aging and the Safety and Independence Support programs. Previous work assignments have included research, budgeting, and management responsibility for numerous social service programs. She serves on the Nebraska Planning Council on Developmental Disabilities and Traumatic Brain Injury Council.//2009//

/2010/ Ms. Goomis will observe 36 years with the State of Nebraska in September 2009. //2010//

E. State Agency Coordination

Nebraska DHHS is part of a coordinated funding committee that encompasses Vocational Rehabilitation, MHCP, the Developmental Disabilities Council, League of Human Dignity, Aged and Disabled Medicaid Waiver, Easter Seals Society, United Cerebral Palsy, the Disabled Persons and Family Support Program, and other private non-profit programs to assure that individuals receive services for which they are eligible. This committee of providers and

advocates has met to discuss individual care plans and find solutions which make the most efficient use of program resources for the past eighteen years.

/2009/The Coordinated Family Committee continued to meet on a bi-monthly basis to review and discuss funding of individual cases. Next year, the committee plans to have a series of presentations to expand the committee's knowledge of other resources that offer funding assistance. In addition, they will be part of the review and rewriting of MHCP regulations//2009//.

/2009/Child Abuse Prevention Treatment Act (CAPTA) is improving Nebraska achievement under the federal mandate. EDN has collaborated with Juvenile Court Judges, child development experts, and Protection and Safety CPS staff to provide statewide training to all professionals and families involved in child abuse and neglect court system. EDN has provided several trainings to assist all entities to understand the law and to work together to integrate the system.//2009// ***/2010/The collaboration has been expanded to include; children & family mental health providers, Family Court Judges, family and juvenile court attorneys.//2010//***

/2009/ Since 2005, there have been trainings on the local level on CAPTA to CPS and EDN workers. These trainings are now on-going to work on issues and problems surrounding implementation of the mandate.//2009//

/2009/ The EDN Program Coordinator participates on the Newborn Hearing Screening (NHS) Advisory Committee under Public Health NHS manager. The committee began in 2006 and meets quarterly. The NHS is to establish an Early Hearing Detection Program and a single point of entry for service with referrals made to the EDN Services Coordinators. The EDN Services Coordinators have been trained on the NHS services.//2009//

The Disabilities Determination Unit (DDU) for Social Security and SSI is located in the Nebraska Department of Education. The DDU sends notification to MHCP on a regular basis of children determined eligible for SSI, at which time MHCP sends a notice to the family describing possible services they may receive and how to apply. This relationship ensures that families receiving SSI for their children are notified of their potential eligibility for services.

/2009/ The Disability Determination Unit of Social Security provides a continual stream of referrals to the MHCP. As the result of the notification of SSI eligibility, MHCP workers have been able to provide immediate notification to families regarding the availability of services through SSI-DCP. //2009//

With the administration of Nebraska's Title V/MCH Block Grant located within the Lifespan Health Services Unit, abundant opportunities exist to coordinate Block Grant investments with a wide range of MCH programs and activities funded through other sources, including WIC, CSFP, Immunizations, and Reproductive Health. Then, with the Lifespan Health Services being in the same section of the Division of Public Health with the Offices of Rural Health, Minority Health, Public Health, and Health Promotion, another and even more significant level of collaboration opportunities exist. References to these collaborative efforts are found throughout this application.

Within the larger Department of Health and Human Services, the Lifespan Health Services has ongoing and active partnerships with Child Care Subsidy, Child Care Licensing, and Protection and Safety. It has expanded its collaboration with Behavioral Health, in conjunction with the Mental Health Component of the ECCS grant, the SAMSHA SIG project, and the perinatal depression grant.

The Nebraska Department of Education (NDE) is an active partner with Lifespan Health Services in carrying out early childhood programs and initiatives, including ECCS. The Title V/MCH Director is reciprocally active in the NDE's Early Childhood Policy Initiative, the development of Early Learning Guidelines, and administration of the statutorily required READY Act (early

learning materials for all Nebraska newborns and their families).

Nebraska Title V has a long-standing working relationship with the state's urban health departments. Both the Douglas County Health Department and the Lincoln/Lancaster County Health Department currently receive Title V funds for specific activities, but each have been partners in a wide range of initiatives. For instance, representatives of the Douglas County Health Department actively participated in the recently completed needs assessment and are active in current projects such as Safe Sleep. A staff person with the Lincoln/Lancaster County Health Department (LLCHD) also participated in the needs assessment process and has been active in the Breastfeeding Initiative. ***/2010/Both urban health departments have representatives participating in a Infant Mortaty Disparity work group. This work group will be described in greater detail later in this report/application. In addition, the Douglas County Health Department, through a contract, is developing specific capacity to further develop and promote preconception health interventions in the Omaha area.//2010//***

Nebraska Title V also works with smaller local health departments and other community health agencies, both as a funder and a collaborator. As previously stated, $300,072 has been set aside for contracts with Nebraska's LB 692 designated local health districts for the purposes of building and sustaining MCH infrastructure. In addition, as the newer local health districts have matured, their staff has become increasingly engaged in state-level activities and initiatives, such as Safe Sleep and Breastfeeding Promotion and Support.***/2010/Funds are no longer set aside for local health districts for the purpose of building and sustaining MCH infrastructure. A number were awarded funds for other projects. See Section B Agency Capacity.//2010//***

Nebraska's federally qualified health centers continue to be key partners in serving the MCH population. The Charles Drew Health Center, through its Healthy Start program, provides enabling services to the perinatal population of northeast Omaha. Lifespan Health Services works whenever possible to connect state level activities with Omaha Healthy Start. ***/2010/ Staff with Omaha Health Start, Charles Drew Health Center are currently participating in the Infant Mortality Disparity work group.//2010//***

Local health departments, federally qualified health centers, and applicable Title V supported community projects are key partners in assuring that pregnant women access prenatal care and help identify pregnant women and children eligible for Medicaid services. In turn, Medicaid presumptive eligibility for pregnant women continues to be determined by many of these providers.

Nebraska Title V continues its working relationship with the Primary Care Office by sharing data and information. The Primary Care Office assisted with geocoding as part of the comprehensive needs assessment.

Nebraska Title V works closely with a number of programs and departments within the University of Nebraska Medical Center (UNMC). The Munroe-Meyer Institute is a close collaborator on a number of CSHCN projects. A new relationship was established with the University of Nebraska ---Omaha, for the CSHCN component of the comprehensive needs assessment. Many other working relationships exist with various faculty and staff throughout Nebraska's university systems, including development and support of internet-based services for families of CSHCN and for school nurses.

Nebraska has a relatively young Masters in Public Health program, a combination degree program sponsored by the University of Nebraska Medical Center and the University of Nebraska at Omaha. The MPH program finished its first semester in operation in May, 2002, and since has acquired accreditation. This program, along with the newly established Great Plains Public Health Leadership Institute, provide opportunities for collaborations around staff development and building public health capacity./2008/ The College of Public Health was formed in 2007.//2008//

Collaborations were expanded during FFY 2004 through Together for Kids and Families, Nebraska's State Early Childhood Comprehensive Systems project, including HHSS and Department of Education staff working with program and services for homeless students and families. In addition, Office of Family Health are actively working with Medicaid Managed Care staff on a prenatal care quality improvement project.

An ongoing project that has depended on a close partnership with the Nebraska Department of Education is implementation of the READY Act. This act, passed by the Legislature in 2002, requires that materials be provided to the parents of all infants born in Nebraska that promote early learning opportunities and healthy, safe child development. The Title V/MCH Director was the lead HHSS contact for this project, and helped coordinate the health and safety content of the materials and planned for the distribution. The Department of Education took the lead in the overall design and production. A Title V/MCH funded project field tested the materials with young parents. The booklet, "First Connections with Families" was completed late in 2003, and distribution started in January 2004. The Perinatal, Child and Adolescent Health Unit is responsible for ongoing distribution. Participating hospitals distribute to new parents, while other parents receive via the mail 3-4 months after birth.

/2009/ Lifespan Health Services staff continues to collaborate with the Nebraska Department of Education in the distribution of the First Connections with Families booklets to Nebraska families of newborns. During FFY 07, 20,978 booklets were mailed directly to families with newborns. Other families received their copy at the birthing hospital. Twenty-five Nebraska hospitals distributed the booklets to newborn families. The booklet was translated into Spanish with other federal funds. A tear-out postcard was placed in the second edition of the English version of "First Connections" that families can use to request a Spanish copy. Twenty-eight Spanish booklets were mailed to families of newborns, as requested.//2009//

/2007/ Over the past year, collaborations with Medicaid and EPSDT have been expanded and enhanced through various projects and initiatives. /2008/Lifespan Health Services//2008// is working closely with Medicaid/EPSDT personnel in operationalizing child care health consultation through Medicaid-contracted public health nurses. This arrangement is a direct outgrowth of Nebraska's ECCS project, Together for Kids and Families. MCH Planning and Support is also working with Medicaid/EPSDT staff in the start up of a new community based Title V project in northeast Nebraska, in the provision and financing of enabling services including home visitation. Medicaid/EPSDT staff are also participating in the National Center for Children's Health Care Quality's Newborn Hearing Screening-Medical Home Learning Collaborative. These are just a few examples of the routine, working relationship between Title V/MCH and EPSDT.

Nebraska continues to offer presumptive Medicaid eligibility to pregnant women, with Title V/MCH community based providers either offering eligibility determination or making referrals. During this past year, Healthy Mothers, Healthy Babies helpline was assessed and plans are underway to make it a more useful tool for connecting pregnant women and infants to health care and Medicaid. In addition, /2008/Lifespan Health Services//2008// is administering a pilot project for supportive services for pregnant women, funded through allocated TANF funds. This project, just getting underway, includes a network of providers in the Omaha community that together will provide supportive services and make referrals to care and other resources, such as Medicaid. //2007//

/2008/ The TANF funded project, described above, will be completing its pilot phase at the end of calendar year 2007. TANF funds have again been budgeted for this project for the SFYs 2008 and 2009. Contractor(s) will be selected through a competitive process, to continue/replicate successes identified during the pilot phase.//2008//

/2009/ The TANF funded project selected in FFY 2008 is located in Lexington, Nebraska, and the contactor is Lutheran Family Services. The focus is on improving birth outcomes for at-risk women, particularly racial/ethnic minorities and new immigrants.//2009//

/2009/ Of note during FFY 2008, the Divisions of Children & Family Services and Medicaid & Long Term Care jointly issued a Request for Bids for home visitation services. This joint RFB was in response to two, distinct appropriations made by the Nebraska State Legislature in 2007. One appropriation was for home visitation as secondar prevention for child abuse and neglect. The other appropriation was for nurse home visitation to improve outcomes for Medicaid eligible pregnant and parenting teens. Lifespan Health Services collaborated in the developement of the RFB, particularly in establishing expectations for evidence-based models.

DHHS Division of Medicaid and Long Term Care also developed an interactive curriculum to promote provider screening for social-emotional and behavioral development in children ages birth to five years. Continuing education credits are available to physicians and nurses who complete the curriculum. Plans are underway to develop similar curriculums for development in children 6-9 years and 10-17 years. These curriculums add to and are located with the curriculum developed by Lifespan Health Services for perinatal depression screening.//2009//

/2010/ Lifespan Health Services continues to develop and sustain a wide range of partnerships. During FY 2009, the Adolescent Health Program applied for and received a mini-grant from AMCHP to support systems planning for adolescent health. Using the ECCS framework as a model, the Adolescent Health Coordinator has assembled a wide range of partners to beging developing a framework specific for adolescent health and well being. Partners include local health departments, family representatives, community advocates, school sytems, state department of education, child welfare, Medicaid managed care for mental health, and others. This collaborative project will continue into FY 2010 with the support of Title V funds.//2010//

/2010/ The MHCP program is working in collaboration with Boystown on a medical home model which includes 9 medical practices from across Nebraska. This project provides the practices with supports to assist with transitioning their practices to medical homes for the patients that they are serving.//2010//

/2010/ The MHCP Program will be working with the Answers4Families website to provide an overview of our clinic services and their staff. The collaboration will also build a resources network for families to access local resource information to help meet their identified needs.//2010//

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	18.4	21.8	15.2	17.3	
Numerator	225	219	194	224	
Denominator	122049	100490	127665	129796	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a					

3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 HDD data is released in October of 2009.

Notes - 2007
2007 HDD data is released in October of 2008.

Notes - 2006
2006HDD data is released in October of 2007.

Narrative:
/2008/Nebraska Health and Human Services contracts with the Nebraska Hospital Association for annual Hospital Discharge Data which is generally available in October of every year (2006 in October 2007). In the past the software and technical support has been provided by a private insurance company. In 2004 the company discontinued support of the software and as a result the reporting dropped form 95% of Nebraska hospitals to 82%. Therefore it is unclear what Nebraska rates truly are. There is however a increase over the past 5 years.
The highest incidence of hospitalization is to children 1-4 years of age.

Nebraska no longer has an asthma program at the state level and efforts to conduct surveillance have been slow. //2008//

/2009/
Nebraska's Hospital Discharge Data (available in October of each year) reporting continues to improve, however issues have not been completely resolved. Nebraska does not have an Asthma Program. The last epidemiological report was completed in 1998. This report found that the highest emergency room and hospitalization rates for asthma occurred among children under the age of 14. As an example the e-room rate for 0-4 year olds was 32.6 and 5-14 years was 35.4 per 10,000 while the total state rate was 24.6. //2009//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	81.7	98.7	98.8	98.3	98.4
Numerator	10315	12575	12933	13277	13402
Denominator	12618	12743	13094	13510	13625
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
/2008/Medicad enrollment has increased slightly and is maintaining high compliance with the initial periodic screen for infants. Nebraska does well on EPSDT until the child reaches 3 years of age and older and we see a considerable drop in periodic screening. //2008//

/2009/ There is no change in this indicator.//2009//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	91.9	86.6	87.7	84.7	85.9
Numerator	1096	862	876	866	972
Denominator	1192	995	999	1023	1131
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Medicaid was asked to verify and interrupt the drop. Staff stated 2003-2005 should have been reported 82.9, 86.6, 86.6%.

Narrative:
/2008/Nebraska had a considerable drop on ESPDT rates for CHIP over the last fiscal year. Enrollment in CHIP is up and the number of infants screened is higher despite the rate reduction. The data for this indicator is a sub-set of indicator #02HSCI so, while the overall Medicaid Kids Connection initial periodic screens have hit nearly 100% over the past couple of years CHIP enrollees have not. //2008//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	71.1	63.0	66.4	72.5	72.7
Numerator	18670	16429	17712	18916	18669
Denominator	26273	26085	26659	26096	25677
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births). Over 2% of the data for this PM is missing/unknown.

Notes - 2006

Over 6% of the data for this PM is missing/unknown.

Narrative:
/2008/ In 2005 Nebraska Vital Statistics converted to the 2003 standard NCHS birth certificate. One significant change was the data field first prenatal care visit which previously was reported by month and is now reported by actual date (more accurate). These data sources are not the same and are not comparable (verified by NCHS staff).

Data for 2005 and 2006 remains provisional. There is a slight improvement in the provisional data over the two years. Because of the provisional nature of the data it is unclear if any change has occurred. Staff has been making informal efforts to inform partners of the changes in he data //2008//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	96.5	96.8	96.9	96.9	97.0
Numerator	152470	153502	154580	155320	159496
Denominator	158000	158500	159580	160320	164496
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
/2008/ This indicator remains stable hovering in the 97% range. //2008//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	57.8	61.3	61.7	63.6	64.2
Numerator	17525	18869	19384	20265	20948
Denominator	30301	30763	31427	31870	32633
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:

/2008/ Recruitment and retention of dental providers remains a significant issue for Nebraska's children. //2008//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	32.8	32.6	36.5	37.0	35.1
Numerator	938	967	1101	1375	1149
Denominator	2858	2964	3016	3715	3278
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Num = NE CONNECT number of children 15 and younger receiving services (MHCP and/or SSI-DCP)FY 2007.

DEN = Table 7 SS1 payments Dec, 2007 via Healthy and Ready to Work

Narrative:
/2008/The Nebraska CSHCN (MHCP) program does not provide rehabilitative services. So this indicator measures those who received any services in the 2006 funding year. The number served has decreased while the number of children receiving SSI has increased causing a reduction in the indicator //2008//

/2009/The number SSI Beneficiaries have increased while the number receiving benefits through Nebraska's Medically Handicapped Children's Program have decreased. //2009//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2007	matching data files	8.4	5.8	6.9

Narrative:
/2008/Nebraska converted to the electronic 2003 NCHS birth certificate format in 2005. Staff have been formed a work group to address low birth weight and prematurity. An extensive problem analysis has been conducted in which both poverty and racism have been identified as contributing factors.//2008//

/2009/A report from the workgroup is attached to the Needs Assessment Summary (Section IIC).//2009//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	matching data files	4.3	6.3	5.5

Narrative:
/2008/While other indicators demonstrate a negative gap between the Medicaid and non-Medicaid population the infant mortality rate continues to lower for the Medicaid population. //2008//

/2009/The infant mortality rate is now higher for the Medicaid population for the first time since 2003.//2009//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	matching data files	74.7	89.5	83.6

Notes - 2010
There was some data loss in the file matching there were individuals who were unable to be matched so cases were dropped. This affects the overall rate being reported (Vitals data alone reports 73.2%).

Narrative:
/2008/Nearly 43% of deliveries were paid for by Medicaid in 2006. Medicaid's policy of presumptive eligibly should eliminate problems with access early prenatal care. Thus these differences are more likely attributable to characteristics of the population and not the Medicaid program. //2008//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	matching data files	58.7	69.5	64.1

Notes - 2010
There was some data loss in the file matching there were individuals who were unable to be matched so cases were dropped. This affects the overall rate being reported (Vitals data 72.5%).

Narrative:
/2008/ This data has changed very little over the past few years. Getting early prenatal care and then consistent prenatal care is a challenge for those receiving Medicaid services.//2008//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	185

Narrative:
/2008/These levels have not changed in a number of years.//2008//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2008	 133 100

INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2008	 185 185

Narrative:
/2008/These levels have not changed.//2008//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	185

Narrative:
/2008/These levels have not changed.//2008//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND	2	Yes

SURVEYS Hospital discharge survey for at least 90% of in-State discharges		
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
/2008/Nebraska continues to improve and refine the data linkage capacity. While The "MCH Program" has the ability to obtain data in a timely manner it is at various levels of proficiency and experience.

Nebraska has been fortunate to receive funding from CDC for the Early Hearing Detection and Intervention Tracking, Surveillance, and Integration project which will further SSDI efforts by linking the birth, newborn hearing, and Connect (CSCHN)databases.

The linkage of the birth file with the WIC eligibility file has been the least successful on an annual basis and capacity improvements will be a focus of data linking projects of SSDI. As described in detail in HSCI #01 the Hospital Discharge Database is currently experiencing reporting issues that should be cleared up for the 2006 dataset.

Nebraska PRAMS has recently been awarded a five-year cooperative agreement carrying its activities into 2011. //2008//

/2009/ Nebraska is set to fully implement the Nebraska State Immunization Information System by December 2008. The NESIIS is linked with Vital Records system. Other changes in the up-coming year are the implementation a new computer system for Medicaid and then WIC. //2009//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	**Does your state participate in the YRBS survey? (Select 1 - 3)**	**Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)**
Youth Risk Behavior Survey (YRBS)	2	Yes
Youth Tobacco Survey	3	Yes
Nebraska Risk and Protective Factor Student Survey	3	Yes

Notes - 2010

Narrative:
/2008/The Nebraska YRBS is conducted biannually and is currently being administrated (2007). However, because the largest school district (Omaha Public Schools) does not participate the results are not generalizable to the entire state.

The Pediatric Nutrition Surveillance System is WIC data aggregated by CDC. Nebraska uses this

data on a limited basis as it is restricted to a sub-set of the population.

Perhaps the best source of information about the tobacco use by youth is the Nebraska Risk and Protective Factor Student Survey (NRPFSS) which was administered in the fall of 2003 and 2005 to Nebraska students in grades 6, 8, 10, and 12. The survey is designed to assess adolescent substance use, anti-social behavior, and the risk and protective factors that predict adolescent problem behaviors. The Nebraska survey is adapted from a national, scientifically validated survey and contains information on the risk and protective factors that are: 1) locally actionable, 2) not obtainable through any other source, and 3) more highly correlated with substance abuse. One of the goals of the survey was to provide schools and communities with local level data to assist in planning comprehensive, evidence-based prevention initiatives.//2008//

/2009/DHHS has collaborated with the Nebraska Department of Education to convene the school-based student health survey initiative. This initiative brought together educators, researchers, public health, and data users to discuss the three surveys. The discussion was about methodology, response rates/participation, and decreased school time. A set of recommendations has been made and are being vetted to funders and administrators. The goal is to implement all three surveys successfully while minimizing school interruption. //2009//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The investment of Title V funds in Nebraska is driven by a number of key factors. The first set of factors is the MCH/CSHCN priorities identified through the needs assessment completed in 2005. These priorities will guide funding decisions for FFY 2006 and beyond. A second important factor was the technical assistance consultation provided by Donna Petersen in 2001. This consultation provided recommendations for how to balance investments in infrastructure and local services. Next, Nebraska's emerging local health districts, supported through tobacco settlement funds, have offered a unique opportunity for building MCH capacity. Finally, though the State's financial status is not as gloomy as in recent years, fiscal constraint is still needed.

Between 2000 and 2003, Medically Handicapped Children's Program applications have more than tripled. Going from 132 in 2000 to 580 in 2003, yet the available funding has stayed the same. We continue to balance between the rising need and the stagnant funding to meet the increasingly complex medical needs of CSHCN..***/2010/ The MHCP program for 2008, had 316 new referrals to the program for children with special health care needs under the age of 18. We continue to see a steady number of new referrals but have recognized in those a decline in the number of birth defects to the spinal cord. This decline is attributed to the increase in Folic Acid in prenatal care.//2010//***

Thus, decisions on the allocation of Title V funds continues to be a balance between meeting the needs of the MCH/CSHCN populations, capitalizing on opportunities to build infrastructure, and sustaining basic, ongoing services in a time of limited financial resources. Even more than in previous years, collaboration with other programs and integration of financial resources is critical to address priorities. In this regard, it must be pointed out that the term Title V Program does not capture the essence of the work carried out through Title V in Nebraska. For both the MCH and the CSHCN populations, the integration of resources, both financial, human and logistical, is key to addressing priority needs. Title V funds are being increasingly invested in basic infrastructure, with the support of other health and human services programs augmenting interventions.

/2008/ In 2006, the number of MHCP applications increased by 9% and the number of applicants without insurance coverage increased by 12%. These figures demonstrate the growing need for medical insurance coverage. MHCP is filling a gap in services, providing necessary medical care to families with children with complex medical needs. ***/2010/ In 2008, the number of application for children with special health care needs under the age of 18 increased by 40%. From that popluation 15% did not have any health coverage. MHCP continues to fill the gap in services, providing necessary medical care to families with children with complex medical needs//2010//***

/2009/ Connect reports indicate a slight decline in the number of MHCP clients covered under Medicaid and private insurance this year. This is due to a modification of the insurance fields on the Connect database in order more accurately track the number of CYSHCN and their insurance coverage. The modification will provide additional information regarding insurance coverage. The system will record the specific name and address of the insurance company providing coverage, along with the insurance coverage period. This will provide current, accurate, and detailed insurance coverage for each MHCP client. It will allow us to track fluctuations in private insurance coverage and increase the ability to track and report data in this area.//2009//

/2008/Each year the need for MHCP services has grown, and continued collaboration with other programs and the inclusion of existing financial resources, when available, has become essential to meeting the medical needs of children. //2008//

/2009/ With increased medical costs and the identification and treatment of rare medical conditions, continual collaboration with other agencies has been essential to providing the

needed services, while maintaining the MHCP budget.//2009//

During FFY 2008, three work groups were established to develop strategies specific to three priority needs: preterm birth/low birth weight; overweight among children and women of reproductive age; and transition to adult services for CYSHCN. The intent of these work groups were to better focus Title V attention on fewer priorities, and deferring to other programs and funders, when doing so would more efficiently address a priority need. For instance, Nebraska's Strategic Prevention Framework State Intervention Grant (SPF SIG) has completed planning for and is investing resources towards the prevention of underage and binge drinking. Thus, SPF SIG was targeting Nebraska's MCH priority need to reduce alcohol use among youth. Other programs and their associated funding sources were similarly addressing unintentional injuries, prevention of child abuse and neglect, and MCH tobacco use.

The three work groups conducted problem analyses, researched current literature, and developed logic models. The recommended strategies developed by the CYSHCN work group addressing transition services will be considered by the Medically Handicapped Children's Program in its planning and program development. The recommended strategies of the preterm birth/low birth weight workgroup and the overweight among children and women work group became the primary basis for the competitive RFA for community-based MCH projects issued in May 2008.

Narrowing down this RFA to fewer priorities was seen as essential to maximizing the potential of the Block Grant. Investing small amounts of funds to address several needs was seen as less likely to improve outcomes. In addition, the logic models developed for preterm birth/LBW and overweight women and children yielded very similar and compelling themes: life course approaches to improving outcomes and eliminating disparities, including pre and interconception health; population-based, primary prvention and wellness models; the importance of community-wide and system level change; and a focus on social determinants of health and health equity. Building community-level interventions around these themes was determined to be important in maximizing Title V as a funding source. //2009//

/2010/Lifespan Health Services formed an Infant Mortality Disparity work group in 2009. This work group will develop strategies to address IMR disparities, one of Nebraska's 10 Priority Needs. The work group is using the same planning methodology as was utilized by the 3 work groups that were active in FY 2008. Three meetings have occured thus far, with the work group members reviewing literature and data related to precursers and they have begun a problem analysis. Through these types of focused planning activities, Nebraska Title V intends to be purposeful and targeted in allocating resources to address the most pressing and significant MCH needs.//2010//

B. State Priorities

Nebraska completed its most recent comprehensive needs assessment in 2005. Ten priority needs were identified. Below is a description of each priority need, NE's capacity and resource capability to address each, and relationships to national and state performance measures. It must be noted that community-based projects addressing priority needs will NOT be known until on or after August 15, 2005. Mid and long range planning for state-level strategies will be initiated early in FFY 2006.

/2008/Lifespan Health Services chartered three workgroups that are actively developing strategies for three priorities. See below.//2008// ***/2010/See updates in Sec. IV A., including the formation of a 4th work group in FY2009. //2010//***

/2007/ Eight community-based projects were identified through a competitive process conducted in FFY 2005. Subgrants were awarded for an initial nine-month period beginning January 1, 2006, with two additional 12-month award periods possible, assuming acceptable performance

and availability of funding. //2007//
/2010/ See Section III B Agency Capacity for details of most recent competitive process.//2010//

1. Reduce the rates of overweight women, youth, and children by increasing participation in sufficient physical activity and improving nutrition.

Following national trends, increasing rates of overweight was identified as a priority need across all MCH populations. Taking the lead in addressing this need has been Nebraska's Cardiovascular Health Program. In collaboration with the Lifespan Health Service's School and Child Health Nurse Coordinator, the Cardiovascular Health Program collected and analyzed BMI data for 40,154 students in K-12 from 235 schools for the 2002/2003 academic school year. The study report, published in June 2004, provided excellent baseline data for the assessment of overweight among Nebraska children as part of the recent needs assessment. In addition, the Cardiovascular Health Program led the development of the Nebraska Physical Activity and Nutrition State Plan, released in April 2005. This plan lays out a comprehensive set of goals, strategies and objectives to be used for intra and inter-agency collaborations for the next 5 years. The Office of Family Health has taken the lead in addressing the objective for increasing supports for breastfeeding, through an initiative that was launched in January 2005. The Office will continue to work with both the Cardiovascular Health Program and the Office of Women's Health in promoting VERB(r) and will help the Cardiovascular Health Program launch the Youth Physical Activity and Nutrition Lifestyle Modification Rx for use in both school and health care settings.

/2010/A work group completed a strategy development process in 2008 to address this need. The logic models created guided the RFA development for community projects funded for the 3 years beginning October 2008. See Section III B Agency Capacity for details.//2010//

Of the National Performance measure, only NPM #11, percentage of mothers who breastfeed their infants at hospital discharge, relates in any way to this priority needs. Thus, a new State Performance Measure # 1 has been chosen for 2006: percent of women (18-44) with healthy weight.

2. Reduce the percent of women of child-bearing age, particularly pregnant and post-partum women, and adolescents who use tobacco and reduce the percent of infants, children and youth exposed to second hand smoke

Tobacco use and exposure to second hand smoke were identified as significant factors impacting a wide range of health outcomes for MCH populations. Nebraska has a strong Tobacco Free Nebraska program that has been an ongoing partner with the Office of Family Health. In 2002 and 2003, in collaboration with Tobacco Free Nebraska, the Lifespan Health Services developed tobacco cessation materials for women of child bearing age and their health care providers. In addition, Lifespan Health Services subgranted funds to community-based organizations to develop local capacity for perinatal tobacco cessation efforts. These materials and the subgranting efforts were financed with tobacco settlement funds. The Lifespan Health Services will continue to build on this working relationship with Tobacco Free Nebraska in promoting tobacco prevention and cessation. For instance, Lifespan Health Services is participating in the development of a tobacco cessation state plan, being lead by Tobacco Free Nebraska.

/2007/ Of the eight community-based Title V funded projects, three report tobacco prevention/cessation activities. //2007// ***/2010/Tobacco cessation is not a specific focus for current community-based projects, but is a component of those addressing preconception health. See Section III B.//2010//***

No National Performance Measures relate to this priority need. Nebraska therefore has selected for 2006 SPM # 2, percent of women of child --bearing age who report smoking in the past 30

days.

3. Reduce rates of premature and low birth weight births for all women, with attention to adolescent pregnancy.

In order to improve overall outcomes for infants, this cluster of events was identified as a priority need. Nebraska Title V/MCH Block Grant funds have long invested in services for pregnant women, including adolescents. These services range from prenatal care, to home visitation, to outreach and translation services. It is anticipated that such services will again be included in the array of local projects funded in FFY 2006 through FFY 2008. In addition, the Office of Family Health has and will continue to work with local initiatives, such as "Baby Blossoms" in Omaha/Douglas County, and its member programs, such as Omaha Healthy Start. In addition, the Office continues to work with the Medicaid Managed Care program on a prenatal care quality improvement initiative. Yet much more needs to be accomplished, particularly related to pre and interconception risks. As identified by Omaha's Baby Blossoms members using Perinatal Periods of Risk methodology, maternal health is key to improving birth outcomes. Over the next year, additional strategy development and partnership formation will be pursued to build capacity in this area.

/2007/ Five community-based Title V projects include this priority among those to be addressed. //2007//

/2008/ A work group was formed in 2007 to further analyze this priority and develop strategies for reducing preterm and lowbirth weight. Work will continue into early 2008, with the completion of an action plan.//2008//
/2010/The work group developed 3 logic models that emphasized life course/preconception strategies. These logic models were incorporated into the RFA for community-based projects, and they formed the basis for Nebraska's application for the First Time Motherhood/New Parents Initiative grant application.//2010//

National Performance Measures #15, percent of very low birth weight infants, #17, percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates, and #18, percent of infants born to pregnant women receiving prenatal care beginning in the first trimester all relate to this priority need. In addition, SPM #5 has been selected for 2006, percent of premature births, and SPM #6, rates of infant death to adolescent mothers (age 15-17).

4. Reduce the rates of hospitalizations and deaths due to unintentional injuries for children and youth.

This priority was also identified in the 2000 needs assessment, with unintentional injuries being the major cause of morbidity and mortality among Nebraska children. Nebraska's capacity to address this issue has its leadership within the Nebraska Injury Prevention Program, Office of Disease Prevention and Health Promotion. This program has long fostered and supported Safe Kids coalitions across the state, and has a strong motor vehicle safety component. The program also plays a key role in monitoring and analyzing injury data, releasing the Nebraska Injury Surveillance Report in August 2004. In addition, Nebraska's Emergency Medical Services for Children program has been an active provider of injury prevention information across the state. The Office of Family Health will continue its close working relationship with these programs, and pursue new endeavors. For instance, the Office of Family Health is leading a Safe Sleep initiative, and both the Injury Prevention Program and EMSC staff are participating in this effort.

/2007/ Four community-based projects are actively addressing unintentional injuries. //2007//
/2010/Injury prevention is no longer a focus for community based projects.//2010//

National Performance Measure #10 will be useful in measuring progress in reducing motor vehicle associated injuries. In addition, a new SPM #9 has been chosen for 2006, hospitalization

for unintentional injuries (per 100,000) for children and adolescents (age 1-19).

5. Reduce the number and rates of child abuse, neglect, and intentional injuries of children.

Intentional injuries were combined with unintentional injuries as a priority need identified through the 2000 comprehensive needs assessment. The identification of prevention of child abuse, neglect and intentional injuries as a separate priority in 2005 marks a major shift for public health in Nebraska. Abuse and neglect, as well as youth suicide and homicide, have traditionally been seen as child welfare, behavioral health, and criminal justice issues. As a priority for MCH, new opportunities emerge for primary and secondary prevention efforts. Over the next several months, the Office of Family Health will be working with the HHS Protection and Safety, Prevent Child Abuse Nebraska, and the Foundation for Children and Families in developing a child abuse prevention plan. Development of the plan will include an analysis of best practices and engagement of community stakeholders. Concurrently, Nebraska's Injury Prevention Program is working with other stakeholders to develop plans related to youth suicide prevention. These and other collaborative efforts will add significantly to our state's capacity to address this priority.

/2007/ Three community based projects are carrying out activities to address this priority. LB 994 passed in 2006 was accompanied by a State General Funds appropriation for shaken baby syndrome prevention materials and activities, in combination with SIDS risk reduction. //2007// ***/2010/The referenced projects were part of a previous funding cycle. One home visitation project currently funded by Title V relates to this priority.//2010//***

/2008/ During 2007, a Sexual Violence Prevention Advisory Committee was formed, with the Title V/MCH Director as a member. This group will provide greater insight into child sexual assault and primary prevention strategies. The Child Abuse Prvention Plan, described above, was issued in 2006, and the Title V/MCH Director as a member of the Prevention Partnership is participating in implementation activities.//2008//

National Performance Measure # 16, rate of suicide deaths among youth aged 15 -- 19, relates to this priority, but does not provide a measure of child abuse and neglect. Therefore SPM # 10, has been selected, hospitalization for intentional injuries (per 100,000) for children and adolescents.

6. Reduce the rates of infant mortality, especially racial/ethnic disparities.

This need was also an identified priority in 2000. Though overall infant mortality rates have shown some improvement over the past 5 years, there is still work to be done to meet 2010 objectives and much more work to eliminate racial/ethnic disparities. The work and capacity development described for Priority Need #3 above is also relevant to this priority. In addition, a continued focus will be maintained on postneonatal deaths, particularly sleep associated infant deaths. The Safe Sleep Initiative, launched in April 2005, has brought together a wide range of stakeholders to develop a shared understanding of sudden, unexpected infant deaths, and members of the initiative's steering committee are currently developing a report of recommendations on prevention messages and system strategies. This state level effort will coordinate closely with that of Baby Blossoms, the Omaha area perinatal collaborative.

/2007/ This priority is being addressed by seven of the eight community-based projects in some aspect of their activities. //2007//

/2008/ Upon completion of the Preterm/Low Birth Weight work group activities, an infant mortality work group will be formed. This work group will further explore IMR disparities and identify best and promising practices for addressing these disparities. Preterm births, along with SIDS, are the major contributers to IMR disparities in Nebraska.//2008// ***/2010/The IMR Disparity Work Group was formed, has met 3 times, and is developing logic models to address this priority.//2010//***

No National Performance Measure provides an adequate gage of progress, particularly related to disparities. Therefore SPM # 7, incidence of confirmed SIDS cases (per 1000 live births) among African American and native American infants, and SPM #8, percent of African American women beginning prenatal care during the first trimester, have been selected for 2006.

7. Reduce alcohol use among youth.

Youth alcohol use was combined with tobacco and other drug use as a priority need in 2000. The separate identification of alcohol use as a high risk behavior among Nebraska youth highlights its contribution to a wide range of poor health outcomes, including motor vehicle injuries and mortality. The Office of Family Health had been an active partner in the State Incentive Cooperative Agreement (SICA), a state/federal partnership to reduce substance abuse among youth ages 12 to 17. But much of the collaborative work thus far has focused on identifying risk and protective factors among Nebraska youth. Much needs to be done to develop public health capacity for alcohol prevention. We can learn from successes achieved through Tobacco Free Nebraska, but an ongoing challenge will be garnering enough resources to invest in this effort. Identifying key partners will be a major initial step in building this capacity.

/2007/ Alcohol use among youth is an identified priority for three of Nebraska's community-based Title V funded projects. In addition, the Adolescent Health Program in Lifespan Health Services has launched "Nebraska Partnerships for Positive Youth Development" as a strategy for addressing alcohol and other risk behaviors among youth. //2007// ***/2010/No longer a specific focus for community based projects, those addressing preconception health address alcohol among women of reproductive age.//2010//***

None of the National Performance Measures relate to this need. A SPM that Nebraska has been tracking the past 5 years will be continued as SPM # 4 in 2006, percent of teens who report alcohol use in the past 30 days.

8. Increase capacity of community-based medical home providers to detect and refer for treatment women, children, and youth with emotional and behavioral health conditions.

Key to the identification of this priority was the CSHCN SLAITS data for Nebraska, which revealed access to behavioral health services to be a significant problem for special needs children and their families. This observation, along with the NE HHS System's extensive work in behavioral health reform, places behavioral health among Nebraska's MCH/CSHCN priorities for the first time. Nebraska's capacity to address this need has been significantly improved through multiple efforts underway, including: the strategic plan being developed as part of Nebraska's Early Childhood Comprehensive Systems grant; the SAMHSA-funded State Infrastructure Grant; and the recently awarded perinatal depression grant.

/2007/ Nebraska's ECCS and SIG grants are now actively addressing this priority, and two contractors have been selected to carry out perinatal depression activities. //2007//

/2009/ EDN Services Coordinators were trained on the medical home model and have utilized this model in serving CAPTA families. This reduces ER visits and the use of County Health Centers for the provision of shots.//2009//

/2009/ The MHCP program is working with stakeholders on a Medical Home Learning Collaborative which involves medical practices from across Nebraska by supporting them in transitioning their practices to the medical home model.//2009//

/2010/ The MHCP Program will hold staff training on the medical home model and be implementing the model into the program's clinic services.//2010//

/2008/ A training for all service coordinators has been planned for the next reporting year regarding infant mental health. Speakers, Paula Zeanah and Julie Larrieu, from Tulane University School of Medicine will present a two day workshop on their multi-year research project. Workers will gain knowledge on identifying characteristics of children with various levels of mental health issues. //2008//

/2009/The Infant Mental Health Conference was held in Omaha and Kearney in May 2007. Paula Zeanah, Ph.D., M.S.N., is a clinical psychologist and a pediatric nurse and is an Associate Profess of Psychiatry and Pediatrics at the Tulane University School of Medicine. Julie Larrieu, PH.D., is a developmental and clinical psychologist, and is an Associate Professor of Psychiatry and Pediatrics at the Tulane University School of Medicine. They provided 2-day training. On the first day of training, they focused on "Psychopathology in Infancy" and on the second day, Dr. Zeanah provided a presentation on "A Relational Perspective on assessment, Intervention, Services, and Self" and Dr. Larrieu provided a presentation on "Therapeutic Intervention for Young Children and Their Caregivers: Child-Parent Psychology." The conference was designed to coordinate services through collaboration and heighten awareness of Infant Mental Health wellness, which referred to activities and experiences that encourage healthy social and emotional development of children in their first few years of life. Mental health professionals and those trained to work with children and families were able to benefit from specialized training that addressed IMH wellness. EDN Services Coordinators attended this conference and MHCP workers received all the materials from the conference.

In 2007, the Infant Mental Health Conference was a success and now EDN plans to begin having yearly conferences on Infant Mental Health Conference.//2009//

/2010/Lifespan Health Services has applied for a Project LAUNCH grant.//2010//

NPM # 16, rate of suicide deaths among youth aged 15 -- 19 offers a limited measure of progress in addressing this need. To further assess our work, SPM # 3 has been selected, percent of women (age 18-44) who report mental health not good 10+ days of past 30.

9. Increase capacity of Title V Programs for Children with Special Health Care Needs to serve increased numbers of children meeting medical and financial eligibility criteria and who are uninsured or underinsured.

In this time of increasing cost of medical services it is difficult to increase the number of families served without increased finances. We are maintaining our services. As Medicaid reform continues we may see a need to tighten or limit the number of clinics or services we are able to provide.

/2007/ Two of the eight community-based Title V funded projects are providing enabling services to the CSHCN population. //2007//

/2009/ Connect reports indicate a slight decline in the number of MHCP clients covered under Medicaid and private insurance this year. This is due to a modification of the insurance fields on the Connect database in order more accurately track the number of CYSHCN and their insurance coverage. The modification will provide additional information regarding insurance coverage. The system will record the specific name and address of the insurance company providing coverage, along with the insurance coverage period. This will provide current, accurate, and detailed insurance coverage for each MHCP client. It will allow us to track fluctuations in private insurance coverage and increase the ability to track and report data in this area.//2009//

National Performance Measure #4, percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for services they need, is directly related to this priority.

10. Build capacity of Title V programs for Children with Special Health Care Needs to provide transition medical and dental clinics for youth with special health care needs 14-21 years.

Through a federal Centers for Medicare and Medicaid Services System Change grant, Nebraska will develop and pilot transition medical and dental clinics for youth with special health care needs. The clinics will incorporate education for resident physicians on the disability related medical conditions that will advance as the youth ages to adult medical care. This will increase the number of physicians familiar with special health care needs and increase the number of knowledgeable physicians in communities to provide a "medical home."

2008/ The portals grant is providing education to faculty of family practice residents regarding disability and CSHCN need for a medical home. Curriculum has been developed and will be distributed to facility at the University of Nebraska Medical Center. //2008///***2010/ The portals grant funding has ended but the MHCP program will be taking the information acquired from the grant and work to address the need for medical and dental transition services within our current clinic services.//2010//***

/2009/ We have increased the capacity of physicians, continue these as transition clinics.//2009///2010/ Transition services will be built into ongoing MHCP clinics as transition clinics have ended with the completion portals grant.//2010/

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	98.7	98.8	100.0	100.0
Numerator	30	153	167	185	545
Denominator	30	155	169	185	545
Data Source					Program Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
545 babies had a presumptive positive or inconclusive screening result for a disease requiring confirmatory or repeat testing(follow up) .
(this number does not include hemoglobinopathy patterns that were indicative of trait/carrier status)

23 out of the 545 expired and reuired no follow up.

a. Last Year's Accomplishments

During the first 3 quarters of this reporting period, the Nebraska Newborn Screening & Genetics Program managed mandated screening for 8 diseases (Biotinidase Deficiency, Congenital Adrenal Hyperplasia, Congenital Primary Hypothyroidism, Cystic Fibrosis, Galactosemia, Hemoglobinopathies MCAD & PKU), and universal (offered to every newborn, but consent required) for another approximately 26 amino acid (AA), organic acid (OA) and fatty acid oxidation (FAO)disorders, via the "supplemental" screen. Effective July 1, 2008 the AA, OA and FAO disorders formerly on the supplemental panel, became part of the mandatory screen because of a regulation revision. This revision which made the number of mandated conditions 28 was supported by the Newborn Screening Advisory Committee, Department of Health and Human Services and went through the public hearing process associated with any State Regulation change.

All newborn specimens from Nebraska newborns were sent to Pediatrix Screening Laboratory. As a result of a negotiated rate of $35.75 for testing and NBS fee (mandatory only, or mandatory plus supplemental) greater than 97% of newborns benefited from the full amino acid and acylcarnitine profiles provided at Pediatrix Screening Laboratory during the first three quarters of this reporting period. Also during this period and as the result of a program managed competitive bid process, the contract was awarded again to Pediatrix Screening, renewable for an additional 4 years. The laboratory was acquired shortly after the contract award by PerkinElmer Genetics, a global company involved with production and consultation for newborn screening laboratories for many years. The new fee beginning July 1, 2008 was $38.50, ($28.50 for laboratory and $10 returned to the state program to help support the provision of metabolic formula and food, dietitian consultation and part of an FTE for a Pediatric Metabolic Specialist to assist the program with initial follow-up communication with newborns' medical homes).

The metabolic foods and formula contracts were supplemented by State General funds and Title V Block grant appropriation. In addition, Title V funding helped support a consultant agreement with the Accredited Cystic Fibrosis Center to assist with follow-up and a consultant agreement with a pediatric hematologist.

The numbers screened can only be reported by calendar year. In 2008 Nebraska had 27,094 births reported (preliminary numbers) to the Newborn Screening Program of which 27,021 were screened. Seventy-three were not screened as they expired by 48 hours of birth. Parents of 97.91% of newborns consented to and their newborns received the supplemental screen during the first 2 quarters when consent was required in order to receive the supplemental screen. During the last 2 quarters all screened babies received the full 28 condition panel. Eighty five of the 86 home births reported to the program were screened. The one who was not screened, expired.

Newborns with disorders were identified and treated early to prevent mental retardation, physical disabilities and disease, and infant death. The following list identifies which conditions were picked up on the screen and for whom early intervention was initiated: 1 with profound biotinidase deficiency and 3 with partial deficiency (treated); 1 newborn with congenital adrenal hyperplasia (classical); 15 newborns with cystic fibrosis; 11 newborns with congenital primary hypothyroidism (1 with compensated hypothyroidism, 1 with treated transient congenital primary hypothyroidism); 4 newborns with medium chain acyl-coA dehydrogenase deficiency (MCAD);3 newborns with sickle cell disease, 1 with sickle Hemoglobin C Disease; 1 Carnitine deficiency due to maternal GA I;1 mild 3-methyl crotonyl carboxylase deficiency (3-MCC);1 methylmalonic acidemia (MMA); 1 Hypertyrosinemia of prematurity;1 Homocystinuria; and1 very long chain acyl-coA Dehydrogenase deficiency (VLCAD).

The program continued to implement in collaboration with the Early Hearing Detection & Intervention (EHDI) program, the NBSAC & EHDI Advisory Committee's recommendation for incorporating/integrating testing of dried blood spots for genetic causes of hearing loss such as

Connexin 26, CMV, Pendred and mitochondrial.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screened, referred, tracked & facilitated treatment for 28 required diosrders as per Neb. rev. Stat. 71-519 to 525.			X	
2. Conducted quality assurance activities with hospitals, contracted laboratory, and referral networks.			X	
3. Provided metabolic foods, special formula, and consultation to patients/families through contractual arrangements.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Newborn Screening and Genetics Program now screens all newborns for 28 required conditions in accordance with the ACMG core panel recommendation. Education, NBS testing, follow-up, referral and treatment and ongoing evaluation and quality assurance activities continue. The metabolic clinic is working to gain IRB approval to participate in Region IV (Great Lakes) long term follow-up data collection for MCAD and other metabolic conditions. Training of three .08 FTE public health nurses has begun, and will coincide with quality assurance/technical assistance visits to birthing hospitals across Nebraska. The joint committees for blood spot and hearing screening will continue to receive updated information and evaluate the evidence around screening newborns for congenital cytomegalovirus, or alternative methods to monitor infants for progressive or later on-set hearing loss. The program continues to monitor the national picture and report on activities of other state's pilot programs, and the Secretary's Advisory Committee on Heritable Diseases in Newborns and Children. Program personnel are active in the Heartland's Regional Newborn Screening and Genetics Council and hosted the 2009 Newborn Screening Workshop in Lincoln.

c. Plan for the Coming Year

The Newborn Screening Program will continue all the above activities, and continue to look for ways to integrate or link the electronic data system with the vital records, early hearing detection and intervention data, immunizations data and birth defects data. As the pilot programs progress and the contracted laboratory develops testing capacity for SCID, and five lysosomal storage disorders the program will ensure the Advisory Committee is apprised of all relevant information. A partial restructuring of the Advisory Committee being considered may facilitate some work groups to review and update program infrastructure such as the short term follow-up procedures, and plans for all hazards preparedness, fiscal sustainability, and electronic data system linkage.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	70	70	67.7	69.1	67
Annual Indicator	66.4	66.4	66.4	65.7	65.7
Numerator	326	326	326		
Denominator	491	491	491		
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	68.4	69.7	71.1	72.5	74

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Weighted data

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
School districts tracked movement and services for children in early intervention by district and this information was added to our computerized database CONNECT, allowing our department to keep closer track the number of verifications by district and provide information to our federal partners Office of Special Education programs (OSEP). Data reported to OSEP (U.S. Office of Special Education Programs) December 1, 2007 indicate that Nebraska served 208 infants ages birth to 1 with disabilities, which is 0.78% of this population. This shows considerable progress from the 0.64% (164 infants) reported for December 1, 2005. Data reported December 1, 2007 indicate that Nebraska served 1361 infants and toddlers, ages birth to three, which is 1.74% of this population, which again shows progress over the number served in 2005 (1.67%). Source: Nebraska Part C Annual Performance Report FFY 2007

OSEP approximates that out of the general population, 1% of infants ages birth to one have special needs, and 2% of the general population of infants and toddlers ages birth to three have special needs. Nebraska's data appear to be cyclical without a defined pattern. In 2006 the Planning Region Teams conducted a self-assessment to identify successful Child Find strategies and referral rates and sources.

Part C of the IDEA which in Nebraska is the Early Development Network, a collaborative relation between the Department of Health and Human Services and the Department of Education, has completed a family survey to determine the satisfaction with services coordination and their educational services. We had a 46% return rate with families reporting satisfaction in their services. For Spring of 2008 our return rate was 59%.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implement supporting parent leadership/mentoring activities to enhance EDN services.		X		
2. Modify the MHCP CONNECT system to provide an electronic billing system, a paperless file system, and automated QA Process.				X
3. Continue to promote the comprehensive Child Find System through the Early Development Network.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Nebraska is implementing a comprehensive Child Find System, intended to enhance the identification, evaluation and assessment of infants and toddlers, birth to age three, with disabilities. Child Find is a state-led, regionally implemented set of activities to get early intervention information to the public, medical providers, schools, child protection services, Migrant and Early Head Start, tribal populations, homeless shelters and child care providers. Regional implementation of Child Find occurs through the Planning Region Teams. Systems Support/Change grants are provided to the Planning Regions to supplement funding for training and special projects including Child Find activities. Regions use several public information strategies for Child Find.

EDN Services Coordinators conducting data collection through Developmental TIPS for children that have been part of this program and are now entering first grade.

Research was completed on computerizing the overall MHCP QA system. MHCP staff are working to implement a computerized process.

Part C of the IDEA which in Nebraska is the Early Development Network, a collaborative relation between the Department of Health and Human Services and the Department of Education, will complete a family survey to determine the client's satisfaction with services coordination and their educational services. For Spring 2009, our return rate was 59% also.

c. Plan for the Coming Year

The EDN program will be working to implement additional supporting parent leadership/mentoring activities to enhance the services that are being provided.

The EDN and MHCP programs are working towards promoting the medical home concept and assisting in professional development activities related to initiatives for infants, toddlers, and young children and young adults.

The MHCP program will be gathering data on transition services to assist youth who are reaching adulthood. The program will be exploring the best way for our program to incorporate the transition component into our clinic services on an ongoing basis.

Information will be gathered to support a Youth Advisory Committee for the MHCP program.

The QA process for the MHCP program will be moved to an on-line support network to assist with evaluating family access to care coordination services and identifying service gaps and barriers. Program staff are reviewing an on-line tool that can assist in gathering information from families on their services to assist in the QA process.

The MHCP billing process will be moving towards an on line billing system. This will provide a paperless system that both families and providers can access at any time to submit and track program billings. This system will also allow families to electronically approve provider hours and submit to the DHHS database for MHCP worker approval.

The MHCP program will be working towards a paperless file system. Our CONNECT database would be able to upload documents, allow for on-line program application for services, as well as open up secure email correspondence with our families and our providers. For the families we serve, this will allow faster and more convenient communication response.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	55	55	55	56.1	55.2
Annual Indicator	53.8	53.8	53.8	54.2	54.2
Numerator	706	706	706		
Denominator	1313	1313	1313		
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	56.4	57.5	58.6	59.8	61

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03. Weighted data.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
We have been collaborating with Boystown through a HRSA grant to develop medical home services for children with special health needs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue participation in a multi agency work group regarding modifications to our CSCHN medical home program which is working with 9 medical practices across the State to transition those practice to medical home model.		X		X
2. Apply knowledge of the medical home model in the provision of CAPTA services through the EDN Network.	X	X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
EDN Services Coordinators will apply their knowledge of the medical homes model in the provision of CAPTA services.

MHCP workers and EDN Service Coordinators will have training through Boystown on the medical home model with additional training for staff and families through the Nebraska Parent Training Center.

Medicaid is contracting for enhanced care coordination to provide case management support to high-cost Medicaid individuals who have multiple health care conditions. Case management support will facilitate coordinated, effective care.

c. Plan for the Coming Year
The MHCP program will be using the information from the medical home training sessions to educate families on the medical home concept. The information that will be provided will be used as a tool to assist families in screening and locating a medical home provider in their area.

The MHCP program will be gathering information to work towards incorporating the medical home model into the medical clinic services that it provides to children and young adults with special health care needs. The program is part of a collaborative movement on the medical home model pilot project which is currently beginning work with 9 medical practices across the state to move those practices to medical home model sites with support. The program will be working in this collaboration to obtain data and resources to assist with adding the medical home model to the services the program provides.

The EDN and MHCP programs are working towards promoting the medical home concept and assisting in professional development activities related to initiatives for infants, toddlers, and young children and young adults.

A medical home pilot will be developed to test the efficiency and effectiveness of this service delivery approach. Authority is provided through Legislative Bill 396 of the 2009 Nebraska Legislative Session.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	65	65	65	66.3	67.2
Annual Indicator	63.5	63.5	63.5	65.9	65.9
Numerator	719	719	719		
Denominator	1133	1133	1133		
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	68.6	69.9	71.3	72.8	74.2

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey. Weighted data.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
CONNECT system has been modified to track the history of families' private health insurance coverage, changes, and usage.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand Medicaid CHIP coverage to children and families with income up to 200% of the Federal Poverty Level under the authority of LB 603, 2009 Nebraska Legislative Session	X			
2. Modify the CONNECT system to allow for data collection of family income information.				X
3. Apply for an implement a Medicaid Home and Community Bases Waiver for Autism Spectrum Disorder	X			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
As part of the Medicaid reform plan, we continue to review the scope of the CHIP program and evaluate coverage options for private employers.

Medicaid staff submitted an HCBS Waiver application to cover Early and Intensive Behavioral Intervention (EIBI) Services for children with autism spectrum disorder.

c. Plan for the Coming Year
MHCP will continue modifications to our CONNECT client database system to capture family income information. The outcome for the change would be to determine what percentage of children accessing our services are over the Medicaid guideline. This will provide us with data on what percentage of children with special health care needs are above the Medicaid guideline and do not have private health insurance.

Medicaid eligibility will be expanded to provide CHIP coverage to children in families with income equal to or less than two hundred percent of the Federal Poverty Level (FPL). As a result of this change, additional children will receive access to Medicaid services across Nebraska. Authority

is provided through Legislative Bill 603 of the 2009 Nebraska Legislative Session.

Medicaid staff will be resubmitting a HCBS Waiver for autism services to incorporate changes authorized by the Nebraska Legislature in LB 27, 2009 session. Changes locate administrative responsibility with the Department of Health and Human Services. Provision of services in expected is expected to begin in 2010 following federal approval of the Waiver application.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	80	80	81.4	83	93.7
Annual Indicator	79.8	79.8	79.8	91.9	91.9
Numerator	327	327	327		
Denominator	410	410	410		
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	95.6	97.5	99.4	100	100

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05. Weighted data.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The DHHS Website has been redesigned to provide a more user friendly, easier access format. Families may also utilize on-line service applications for some programs.

A Youth Panel Listserve has been developed on www.Answers4Families.org to discuss

transitional issues and problem solve.

Part C of the IDEA which in Nebraska is the Early Development Network, a collaborative relation between the Department of Health and Human Services and the Department of Education, has completed a family survey to determine the satisfaction with services coordination and their educational services. We had a 46% return rate with families reporting satisfaction in their services. For Spring of 2008 our return rate was 59%.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue surveying families who have a child enrolled in EDN for the past year.				X
2. Collaborate with Answers4Families website to expand local resource listings to assist families in obtaining services in their area.				X
3. Collaborate with Answers4Families website to provide information and outreach for clinic services for children with special health care needs. This will provide an overview of the clinics as well as provide information on the medical staff.				X
4. Establish a hot-line and a Family Navigator Program to respond to children's behavioral health needs per LB 603, 2009 Nebraska Legislative Session		X		X
5. Develop and deliver TBI awareness training to the Medicaid Waiver Service Coordinators		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Part C of the IDEA which in Nebraska is the Early Development Network, a collaborative relation between the Department of Health and Human Services and the Department of Education, will complete a family survey to determine the client's satisfaction with services coordination and their educational services. For Spring 2009, our return rate was 59% also.

The MHCP Program Manager is meeting with MHCP workers to discuss the development of a process that will incorporate a revised user friendly MHCP Clinic evaluation form.

The program is working towards a Youth/Family Advisory Committee involving clients and/or their family members to assist in developing a process to add transition services into our current clinics and to provide client consultation to the program. The committee would also serve as a source for

information outreach on the medical home model.

c. Plan for the Coming Year

The program will be working with www.Answers4Families.org to assist in adding clinic specific information to their website for Nebraska families to access. Families would be able to look for local MHCP clinics that would meet their child's health needs as well as provide them with information on clinic team members and their professional backgrounds. This change will empower families with information on the medical personnel that would be providing services to their child.

The MHCP program will be working www.Answers4Families.org to build a resource bank of Nebraska services based on the customers needs. Nebraska residents will be able to log into the Answers4Families website and fill out a needs based assessment. From that assessment, the consumer would be directed to a link with local resources that can assist them in getting their identified needs met. MHCP, EDN, and Waiver service contacts will be listed.

The Department of Health and Human Services will be applying for a federal grant through the Administration on Aging for the purpose of establishing an Aged and Disabled Resource Center. The ADRC will serve persons of any age with a disability as well as their family members.

A Network of Care website for behavioral health services will be established by the Behavioral Health Division in DHHS. This website will be a resource for individuals, families and agencies concerned with behavioral health. It will provide information about behavioral health services, laws, and related news, as well as communication tools and other features.

The Medicaid program will be promoting the use of telehealth techniques as a way to improve access to care in rural areas of the state.

The department will be working to establish a Children and Family Support Hotline which shall be a single point of access for children's behavioral health triage through the operation of a twenty-four-hour-per-day, seven-day-per-week telephone line and provide referrals to existing community-based resources. It would also include the establishment of a Family Navigator Program with individuals trained to respond to children's behavioral health needs. Authority for these services is provided through Legislative Bill 603, 2009 Nebraska Legislative Session.

Training curriculum will be developed for Traumatic Brain Injury awareness and delivered to Medicaid Waiver Services Coordinators. Waiver staff will be better able to assess need and identify appropriate services with knowledge.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	10	10	5.2	5.3	55.4
Annual Indicator	5.1	5.1	5.1	54.4	54.4
Numerator	118	118	118		
Denominator	2314	2314	2314		
Data Source					National

					Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	56.6	57.7	58.8	60	61.2

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data. Weighted data.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
A Young Adult Advisory Council (YAAC) specializing in adolescent health care and independent living transition issues was established. The YAAC provided policy input to HCBS Waiver staff related issues.

Work under the CMS Portals grant provided and funded benefits analysis for youth and adults. Five youth were provided information on the use of work incentives for youth receiving SSI/SSDI.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Incorporate transition services into MHCP medical clinics.		X		X
2. Continue to utilize HRSA materials to assist in developing MHCP transitional services within our clinics and expand their				X

use to other programs (ie waiver workers, EDN Services Coordinators, and other specific case workers)				
3. Reorganize the Young Adult Advisory Council under the Department of Education.				X
4. Apply for renewed funding of the Medicaid Infrastructure Grant.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
We are currently using the information obtained from the CMS Portals grant to continue transition services by developing and coordinating the addition of transition services into our current MHCP clinics. The transition piece that will be added to clinic services will include: information and guidance regarding education, employment, housing, as well as medical services needed for each individual to transition into adulthood living as independently as they choose.

Program staff are meeting with the Monroe Meyer Institute of University of Nebraska regarding MMI's future role in MHCP transition services.

Our program is continuing to utilize HRSA materials to assist in developing MHCP transitional services within our clinics and expand their use to other programs (ie waiver workers, EDN Services Coordinators, and other specific case workers)

c. Plan for the Coming Year
The MHCP program will be working on incorporating a transition piece into the medical clinic services that it provides. The program is in the processes of review transition information to assist in determining what the best practice should be for incorporating transition services.

The MHCP and the Waiver programs are working towards a resource database system through Answer4Families which will allow those that transitioning out of the programs a point of access for additional resources in their area.

Additional training will be provided to MHCP program staff on transition services to enhance the outreach of the services. The program will also determine the feasibility of putting health information collected from our clinic services to a zip drive that can be given to transitioning youth, allowing them access to their past medical history.

The MHCP program will be evaluating establishment of a medical home through care management services for those transitioning out of the program. This will ensure that each young adult that transitions out of our program has a medical home in place or the knowledge and tools to be able to acquire a medical home depending on their geographical location.

The Young Adult Advisory Council (YAAC) will be reorganized as the Nebraska Youth Leadership Council (NYLC) sponsored by the Department of Education. This group will be focused on leadership development and transition issues.

DHHS is applying for renewed funding for a Medicaid Infrastructure Grant which promotes employment for workers with disabilities. Grant activities will address the needs of youth

transitioning to adulthood.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	90	83.9	85.4	86.9	83.5
Annual Indicator	82.3	89.1	81	85.2	82
Numerator					
Denominator					
Data Source					CDC NIS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	83.6	85.3	87	88.8	90.5

Notes - 2008
Data is Q3/2007-Q2/2008. The entire 2008 data has not been released by CDC.

Notes - 2007
Data is Q3/2006-Q2/200. The entire 2007 data has not been released by CDC.

Notes - 2006
Nebraska relies on NCHS National Immunization Survey (NIS) for current vaccination estimates. Num and Denom are not provided because they are unknown.

a. Last Year's Accomplishments
The Nebraska Immunization Program is located within Lifespan Health Services. Primarily funded through the CDC, this program administers the 317 and Vaccine for Children (VFC) funds, as well as a Perinatal Hepatitis B project. In FFY 2008, the program supported 86 counties with public clinics across the state, 86 counties with public VFC providers and 218 VFC private providers. The Program also administered, through a subgrant, an immunization registry that includes all public immunization clinics that gave immunizations regardless of age. Nebraska participates in the Hallmark Card program (a card signed by the Governor and First Lady and sent to the parents of all newborns with an immunization message).

Title V funds helped support the costs of the immunization registry, which serves all providers who immunize children and mothers from birth on throughout life. This web-based registry, (NESISS) was piloted and rolled out during 2008.

The administration of a 4th dose of DtaP impacted rates for the full immunization series.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported public immunization clinics and private VFC providers across the state.			X	
2. Implemented new web based immunization information system.			X	X
3. Continued participation in Hallmark Card program.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Nebraska Immunization Program continues to support 86 counties with public immunization clinics and 218 private VFC providers. The web-based reistry has been set up and all users of the old system migrated over to the new one. Enrollment and training is underway for private providers.

An allocation of Title V funds continues this year to the Immunization Program, as partial support for the registry.

The program is making plans to pilot flu immunizations in a limited number of schools (2 urban/2rural).

c. Plan for the Coming Year

Implementation of the web based immunization registry (NESISS) will coninue in the private sector and for special populations and activities, such as refugee programs, international travel vaccinations, and emergency disaster response. Enhancement to the system include perinatal HepB management module, barcoding of vaccine inventories, and other adjustement to the system to make it easier and more efficient to enter data.

Preparations for the fall 2009/winter 2010 flu season will be a focus for the Department and the Program. The school-based flu immunization pilots will be launched.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	18	17.5	17.7	15.9	16.6

Annual Indicator	17.8	18.1	16.3	18.1	17.8
Numerator	670	690	616	687	655
Denominator	37702	38097	37844	37863	36878
Data Source					Birth File, Census Est.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	17.4	17.1	16.7	16.4	16.1

Notes - 2008
Birth file is not complete or cleaned.

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births).

a. Last Year's Accomplishments
For the Nebraska Reproductive Health Program, the past calendar year saw a continued decline in adolescent users dropping from 19% of total Title X users across Nebraska to18% of the unduplicated clients. In an effort to address the falling numbers of adolescent clients, Nebraska Reproductive Health staff worked with Nebraska Delegates on potential marketing avenues. These avenues have been addressed through training supported through Development Systems, Inc., review of clinic operations to assure appropriate adolescent hours, review of current marketing and outreach approaches, and assuring that the Delegates have planned for implementation of future programming in their service areas to reach the adolescent population.

Examples of marketing efforts included: delegate use of the world-wide web and pages such as My Space and Facebook; links to the individual Delegate websites from the Nebraska DHHS, Nebraska Reproductive Health website; development of posters and handout materials addressing parental involvement and sexual coercion and use of community education opportunities to discuss services available and reproductive health/life-course health decisions. Community education was further supported with an internal allocation from Maternal Child Health to Nebraska Reproductive Health for the support of community education in the statewide Title X program. Each Delegate received an amount proportionate to the Title X award that they received to forward their community education efforts.

The Adolescent Health Program continued to promote and incorporate the positive youth development framework and philosophy into current work activities and projects. The Adolescent Health Coordinator presented information to Family and Consumer Science teachers on teen brain development and risk and protective factors associated with risk behaviors such as early sexual involvement. She also participated in local Teen Pregnancy Prevention Coalition (TPPS) meetings. The coalition is comprised of personnel from teen pregnancy prevention programs and organizations within Lancaster County. Members were introduced to the positive youth development framework and philosophy and encouraged to incorporate the philosophy into the coalition's endeavors. The Coordinator served as one point of resource for evidence-based pregnancy prevention identified in the previous year strategies as a result of an initiative sponsored by AMCHP and CityMatch . Oversight began on a two-year contract that provides services to women who are pregnant. Contractual services targets an area of the state with high teen pregnancy and STD rates.

Nebraska's Abstinence Education had no active sub grants in 2008. Other activities occurred as a means of keeping the program viable during the interim of unknown status of future federal funding. Abstinence only curriculum training occurred in multiple sites as well as workshops on dating violence and healthy relationships. Program promotion was implemented in a mini media campaign and through televised PSAs aired during the state's high school basketball championships. Work began on implementing a process for soliciting and selecting mini-grant applicants should federal funding materialize for FY 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided comprehensive reproductive health services through the NE Reproductive Health Program, including outreach and community education for adolescents.	X		X	
2. Initiated social marketing campaign to better reach at risk populations through the Reproductive Health Program.			X	X
3. Maintained abstinence education programming and corrdinated with community-based stakeholders.			X	
4. Continued to develope and promote Nebraska's Partnerships for Positive Youth Development.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Nebraska Reproductive Health Program is working on plans for further promotion of clinical services through the implementation of a statewide social marketing plan. The Program has been working with Nebraska CARES (comprehensive cancer program) staff to analyze consumer health profiles accessed through their relationship with National Cancer Institute to carry out this plan. An additional aspect of the plan to increase Title X unduplicated users in Nebraska is sub-granting an equal amount of $30,000.00 to each Delegate Agency for expanded services using the funds that were allocated for service expansion during 2008 and we will continue this defined allocation during the next fiscal year.

The Adolescent Health Coordinator is incorporating the information gained from a workshop presented by the Nebraska Department of Education (NDE). The workshop encompassed state HIV prevention efforts and included information specific to the National Health Education Standards which is another model for implementing teen pregnancy prevention efforts. The Adolescent Health Program launched an Adolescent Comprehensive Systems initiative which includes a component (Healthy Lifestyles) that will address healthy teen sexuality, pregnancy prevention and preconception health. Abstinence Education activities included mini grants awarded and in place to ten (10) organizations across the state. These mini grants focused on continuing the program activities previously implemented.

c. Plan for the Coming Year

The Nebraska Reproductive Health Program and Omaha based programs will work on social marketing strategies that focus on the buying/shopping patterns of the primary demographic group in the areas of focus. The first and primary focus is Omaha and developing a greater

knowledge of Title X and cancer screening through the Title X clinic system. The key strategies to be emphasized are the following: 1. emphasize sliding fee scale, low to no-cost screening; 2. know you health status (this group has a below average health status); 3. cancer screening and prevention, an example would be Gardisil--HPV prevention; 4. preconception health--focus on the family and life-course health; and 5. a well developed referral network and support system for health strategies.

Nebraska Reproductive Health will work with an advertising agency to develop a 'brand'. Continuing work will include the revision of some of the standard marketing and outreach materials, update and expansion of the website, and further development of outreach displays to use at trainings and conferences to promote Title X services.

The Adolescent Health Program will continue to promote evidenced-based approaches for all youth-related health issues with specific attention to teen pregnancy prevention. Youth Development principles and practices will be incorporated into program activities and messages as appropriate. Abstinence Education or alternate teen pregnancy prevention programming will continue dependent on requirements of any federal funding that becomes available. The Adolescent Comprehensive Systems initiative will continue to be developed. A focus will be on the identification and implementation of strategies and activities within the system components. Those that address preconception health and pregnancy prevention will be one of the focused areas within the Healthy Lifestyles component.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	17	45.7	46.8	47.8	48.9
Annual Indicator	44.6	44.6	44.6	44.6	44.6
Numerator	10489	10489	10489	10489	10489
Denominator	23518	23518	23518	23518	23518
Data Source					NE Open Mouth Survey 2004
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	50	50	50	50	50

Notes - 2006
Based on Nebraska Open Mouth Survey of third grades 2004-2005 school year.

a. Last Year's Accomplishments

There were two major Title V funded activities during this reporting period. First was a $100,000 grant to Sealing Smiles. This program examined the teeth of 1162 second grade children, 1101 third grade children and 755 sixth grade children. In addition, the teeth of each child were sealed with fluoride varnish. They referred 851 of these children to their dentist for further routine care and 81 were referred for emergent care.

The second activity funded a fulltime temporary staff person to respond to requests from any viable dental program within the state seeking educational materials from the DHHS dental program. This person responded to 173 requests from private dental programs and 110 from public dental programs, and provided a wide array of educational and incentive materials generally targeting children from birth to 12 years of age.

With PHHS block grant support, oral halth care was provided to students in schools in central Nebraska in September 2008 through the use of adental health van operated by the One World Community Health Centers.

The HRSA and ASTDD supported State Access Workshop (SAW) for MCH Oral Health was conducted in August 2008. The stakeholders attending the workshop agreed on five main goals: 1. Build an effective state oral health coalition; 2. Move forward with a focus on prevention; 3. Develop policy recommendations; 4. Communicate the message that dental care and dental health are critical issues; and 5. Strengthen cultural competence in oral health care, including care for children with special needs.

The group identified potential strategies for moving forward and on the importance of working together to address maternal and child oral health care needs. These strategies include:

Goal 1: Build an effective state oral health coalition -- Identify coalition leadership, determine potential funding sources for supporting coalition formation, identify and engage additional stakeholders, build on volunteer efforts such as Dental Days, use video technology to promote wide participation of oral health stakeholders , and develop an Action Plan for the Oral Health Coalition including ways to increase media exposure and funding for oral health care (including preventive care);

Goal 2: Move forward with a focus on prevention -- Disseminate resources to parents of children participating in Head Start and other early childhood programs, stressing prevention, use non-traditional providers (pediatricians, family practitioners, OB-GYNs, school nurses or other health care workers) to provide preventive care, and encourage appropriate primary prevention among diverse groups including special needs children;

Goal 3: Develop policy recommendations -- Assess the current legislative and regulatory environment, identify options for using current mandates to improve access and care, and make recommendations for new or revised legislation and regulations to address oral health needs;

Goal 4: Communicate the message that dental care and dental health are critical issues -- Compile and analyze existing data showing the extent of oral health challenges in Nebraska, develop dissemination materials to publicize data on oral health, and Develop methods for improving the collection and sharing of data on oral health;

Goal 5: Strengthen cultural competence in oral health care, including care for children with special needs -- Actively engage parents, educate providers on the need to truly listen to parents (promote family centered care), and develop initiatives for addressing cultural and language needs, literacy, experiences and fears, and barriers to access.

The group stressed the need for reaching out to other stakeholders who were unable to attend the meeting as a next step for further developing an action plan. Dan Cillessen, Administrator, Health Promotion Unit, and Paula Eurek, Administrator, Lifespan Health Services Unit, agreed to

further explore the strategies for Goal 1, and maintain communications with stakeholders, providing periodic updates on progress.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. With technical assistance through MCHB/ASTDD, a State Access Workshop was held and recommendations developed to promote MCH/CSHCN oral health.				X
2. Supported school-based sealant project in selected schools, through a project titled Sealing Smiles.			X	
3. Provided educational materials on children's oral health to stakeholders and providers.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Title V funds supported a $50,000 contract to continue the Sealing Smiles Program through June 30, a school-based dental sealant program which: 1) Provided oral health education, prophylaxis, dental sealants and fluoride treatments free of charge to all children in second, third and sixth grade in selected schools in the Omaha area; and 2) Expanded the Sealing Smiles Program by adding schools in Lincoln and in the Panhandle and/or other Western portions of the State.

The NDHHS submitted a multi-year application for HRSA funding aimed at building Nebraska's oral health infrastructure and reducing disparities in access to oral health services among children from 0 to 5 years of age. The proposed oral health services would complement those provided through the Title V-funded Sealing Smiles Program. The program would create preventive oral health services, focusing on children from low-income and minority households or who have special medical needs.

The PHHS Block Grant supported the following oral health projects: a program providing evaluative services to 144 and restorative dental services to 80 children, aged 3 to 17 years in a four county area; Infant Oral Health Program in 2 WIC clinics; oral health services through the Head Start Program in two towns; an elementary school toothbrushing project in 1 town; education for healthcare providers on fluoride varnish application; and Xylitol Chewing GuGum Program at WIC clinics to prevent transmission from mothers to babies.

c. Plan for the Coming Year

Capacity buildining for Oral Health and Dentistry will be a focus if the HRSA grant application if funded. Plans for utilzing other funding sources, particularly the Title V and PHHS Block Grants are pending that notification.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	4.4	4.4	3.8	3.4	3.4
Annual Indicator	3.3	5.3	3.8	4.1	1.5
Numerator	12	18	13	14	5
Denominator	359029	338806	339983	341855	343908
Data Source					Death file, Census Est.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3.3	3.2	3.1	3	2.9

Notes - 2008
2008 death file in not complete.

Notes - 2007
2007 Death file is incomplete, missing out of state deaths and few thousand causes of death.

a. Last Year's Accomplishments
The Safe Kids Nebraska program is responsible for carrying out unintentional injury prevention activities for children 14 and under. One of the programs provided is Safe Kids Buckle Up, which focuses on child passenger safety. In 2008, a total of 50 child safety seat check events/fitting stations were conducted across the state. In that, over 567 seats were checked, 125 seats were distributed. The monetary support came from the Preventative Health and Human Services Block Grant, Safe Kids Worldwide, General Motors, Nebraska Office of Highway Safety and well as local sponsors.

In 2008, child passenger safety certification trainings were held in Scottsbluff, Kearney, Bellevue, and Lincoln. A total of 118 participants were certified. These courses have been implemented since 1999 in Nebraska. These activities have contributed to more children being in car seats from 93% in 2007 to 96% in 2008. This is a significant increase from 1999 in which only 56% of children were restrained. Currently, there are over 450 Certified Child Passenger Safety Technicians across the state in which the Safe Kids program provides technical assistance and grant opportunities. Certification courses are sponsored by Safe Kids and Nebraska Office of Highway Safety through grants and staff time. There was also an All Kids Ride Safe training at Madonna Rehabilitation hospital. The training focuses on educating current Child Passenger Safety technicians on special transportation needs for children.

The Nebraska Office of Highway Safety and Safe Kids Nebraska co-hosted a Child Passenger Safety Technician update in Kearney, NE. A total of 200 technicians from across the state attended.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promoted child passenger safety through the Safe Kids program, including child safety seat check events.			X	
2. Conducted National Highway Traffic Safety Administration certication courses for safety seat checks.			X	
3. Provided classes on special needs child passenger safety through the Nebraska All Kids Ride Safe program.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Nebraska Office of Highway Safety is supporting statewide child safety seat checks by funding 23 fitting stations and four child passenger safety certification classes. Currently, classes have been held in Ogallala, Omaha and Norfolk. The communities of Hastings and Lincoln will be hosting courses this summer and fall. At years end, about 100 more people from various agencies will be trained.

The Safe Kids Buckle Up program continues to support Safe Kids programs throughout the state with funding to plan and implement child passenger safety into their communities. Child Passenger Safety events are held routinely in these communities along with advocacy trainings, educational events for parents/caregivers, and presentations in school systems.

c. Plan for the Coming Year

The Nebraska Child Passenger Safety Advisory Committee will convene its meetings in the fall to discuss the 2010 training schedule as well as other issues affecting child passenger safety. There will also be a trainer from NHTSA participating at the 2010 Child Passenger Safety Technician Update to present a "train the trainer" model to technicians on bus safety and child care provider advocacy.

Safe Kids Nebraska will continue to utilize Safe Kids Buckle Up grants to help communities conduct child safety seat check events, educational programs as well as trainings.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			35.8	48.8	56
Annual Indicator		35.1	47.9	55.1	65.2
Numerator					
Denominator					
Data Source					National Immunization

					Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	66.5	67.8	69.2	70.5	71.9

Notes - 2008
76.42% of woman reported initiating breastfeeding of those 65.2% reported breastfeeding longer than 180 days. However, only 35.3% reported exclusive breasting over 180 days.

Notes - 2007
Data source is CDC's National Immunization Survey, 2006 (weighted data).

Notes - 2006
Data source is CDC's NIS, 2005.
Verified with 2006 PRAMS indicated that 80% have attempted to breastfeed (ever) and 44.5 still breastfeeding at the time of survey.

a. Last Year's Accomplishments
Breastfeeding peer counselor programs operated in three WIC Local Agencies. The State WIC Breastfeeding Coordinator, one WIC Local Agency Breastfeeding Coordinator and the Breastfeeding Coordinator with Nebraska's chapter of the AAP attended the United States Breastfeeding Committee's Conference on Coalitions in January 2008. A WIC Local Agency, through a contract provides the service of a certified lactation consultant to WIC breastfeeding mothers.

With Title V/MCH Block Grant support, a contractor worked with stakeholders to begin planning for a Nebraska Breastfeeding Support Coaltion. The contractor's report provided an outline of steps to move forward in forming a coaltion and to generally advance the cause of breastfeeding promotion and support in Nebraska. The report may be found at http://nebreastfeeding.org/.

Two community based Title V funded projects selected through a competitive process in 2008 include work place breastfeeding promotion and support as activities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued Loving Support Breasfeeding Peer Counseling program in selected WIC sites.	X		X	
2. Provided training to WIC staff on breastfeeding promotion and support topics.				X
3. Initiated development of a Nebraska Breastfeeding Support Coaltion, through a contract funded by Title V.				X
4. Workplace supports for breastfeeding included in Title V community-based RFA; two projects selected and funded that address such supports.				X

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Breastfeeding peer counselor programs continue to serve clients in three rural WIC local agencies. In addition to providing client services, breastfeeding peer counselors in these agencies develop and participate in breastfeeding promotion and support activities throughout their communities and collaborate with community partners whenever possible. In October 2008 a Breastfeeding Peer counselor program was started at Douglas County Health Department, serving two clinics, Charles Drew and Midtown. The breastfeeding peer counselor supervisor and five peer counselors were trained using USDA's Loving Support Breastfeeding Curriculum. The current five-year breastfeeding goal selected to be worked on by the state WIC agency and all Local WIC agencies is related to the rate of exclusively breastfed infants: by August 1, 2013 increase the percent of exclusively breastfed infants at 6 months of age. Strategy: Provide encouragement, education and support for mothers to exclusively breastfeed for the first six month. The State WIC Breastfeeding Coordinator serves as the contact/host for the bi-monthly State Breastfeeding Coalitions Teleconferences, sponsored by CDC and the USBC.

A second contract was executed, using Title V funds, to continue work in developing a Nebraska Breastfeeding Coalition. The contactor has focused on governance, membership structure, and financing strategies, and is actively working with stakeholders from across the state.

c. Plan for the Coming Year

Breastfeeding Peer Counseling programs will continue in three WIC Local Agencies. The WIC Program will continue work on action steps of the five-year goal to increase the percent of exclusively breastfed infants. All WIC Local Agency Breastfeeding Coordinators will attend a meeting to identify ways to communicate and share resources and ideas. The breastfeeding coordinators will attend a training event to learn how to incorporate the "Building Breastfeeding Competencies for Local WIC Staff" as part of training for all WIC local agency staff. In April 2010, WIC staff attending the WIC/CSFP meeting will attend a breastfeeding competencies session that will focus on job-specific competencies for promotion and support of breastfeeding.

The contractor will have completed work to organize Nebraska's Breastfeeding Promotion Coalition. Lifespan Health Services Unit will have representitive participation in the Coaltion, and work with the members to support its further development and maturation as an organization.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	95	99	99.7	99	99.9
Annual Indicator	98.2	99.6	98.9	99.0	99.3
Numerator	25966	26179	26615	26669	26791
Denominator	26443	26293	26898	26948	26972
Data Source					Program Data

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Of the 151 infants not screened 7 were refusals. The denominator is births - 112 infant deaths.

a. Last Year's Accomplishments
Nebraska Revised Statute SS71-4742 established that newborn hearing screening would voluntarily become the standard of care and that 95% of newborns would be screened for hearing prior to hospital discharge. During calendar year 2008, 100% of the 63 birthing facilities were conducting newborn hearing screening and all but one were conducting the screenings during the birth admission. Hospitals reported screening the hearing of 99.2% of the newborns during birth admission. The average refer rate was 4.0%. Outpatient re-screenings and/or diagnostic evaluations were completed for 88.0% of those needing follow-up services. Follow-up services were initiated at an average of 29.0 days of age. There have been 40 infants identified with a permanent childhood hearing loss, an incidence of 1.5 per thousand newborns. The average age of identification was 76.4 days, with 72.2% diagnosed prior to 3 months of age. Of the 40 infants identified with a permanent hearing loss, 72.5% were verified for special education services through Part C and 96.5% of those were verified prior to 6 months of age. Of the infants identified with permanent hearing loss, 78.4% were identified as having a medical home.

During this time period, a primary focus of the NE-EHDI Program has been to strengthen family support for families with young children recently identified with hearing loss. Through close collaboration with the new Nebraska chapter of Hands & Voices, significant progress is being made to establish a Guide By Your Side program to provide family-to-family support and to extend the active follow-up of the NE-EHDI Program prior to a baby being categorized as "lost to system." Progress is also being made in developing a weekend workshop in March, 2009, for parents of young children with hearing loss through a contractual arrangement with Boys Town National Research Hospital. Coupled with these two initiatives, a "single point of entry" for families into the early intervention system has been the developed and implemented. The Family Support workgroup, a formal sub-committee of the NE-EHDI Advisory Committee, is progressively taking a guidance role in developing the EHDI family support system.

The Nebraska Children's Hearing Aid Loaner Bank (NCHALB) has completed its first year of operation. A partnership between the University of Nebraska-Lincoln (UNL) audiology department, the Nebraska Association for the Education of Young Children (NeAEYC) and the NE-EHDI Program, the NCHALB has 40 new digital hearing aids in stock and has served 26 children ranging in age from 2 months to 9 years of age from across the state. Funding for permanent amplification has been found for eight of the children.

A Memorandum of Agreement was signed between the NE-EHDI Program, the Head Start State Collaboration Office and the Nebraska Head Start Association to provide training and technical assistance about hearing screening to Head Start/Early Head Start programs and to develop a mechanism for these programs to report hearing screening results to the NE-EHDI Program.

The NE-EHDI data system, an integrated module of the state's Vital Records ERS-II system, has been revised to provide for improved functionality for the users in the birthing facilities. Audiologic diagnostic evaluation and risk factor modules were completed. A variety of ad hoc reports were

developed to provide quality assurance reports at both the system and birthing facility levels and to support the analysis of demographic factors associated with various outcomes. A supplemental database to more economically create correspondence to the Primary Health Care Providers (PHCP) and parents, as well as to more easily generate status reports, was developed.

Procedures to retrieve the newborn dried blood spot (DBS), prior to its destruction at 90 days, for identification of congenital cytomegalovirus (CMV), Connexin 26 and 30, mitochondrial, and Pendred syndrome were implemented to assist in establishing the etiology of a congenital hearing loss. To provide the Newborn Screening and the NE-EHDI Advisory Committees with the information to develop evidence-based recommendations for further use of the DBS to identify congenital CMV and to develop an audiologic monitoring system, the University of Nebraska-Lincoln audiology program was contracted to conduct a systematic literature review and to develop a report addressing 11 topics related to congenital CMV.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Administered Newborn Hearing Screening Program as per NE Rev Stat §71-4742, including reporting/tracking provisions			X	
2. Promoted periodic screening of older infants and toddlers through Hearing Head Start and Hear and Now projects			X	
3. Reviewed and revised screening, diagnostic, and referral protocols			X	
4. Continued development of electronic data reporting and tracking system as an integrated module of the Vital Statistics Reporting System				X
5. Through HRSA/MCHB Universal Newborn Hearing Screening and Intervention grant, supported implementation of medical home, family-to-family support systems, and professional development of related professionals				X
6. Through CDC EHDI cooperative agreement, planned integration of electronic data reporting system with related child data systems				X
7.				
8.				
9.				
10.				

b. Current Activities
Current program objectives are to:

Fully expand the integrated electronic data reporting system to support the electronic reporting of audiologic and birth defect results and to strengthen linkages with related early childhood data systems.

Provide quality assurance reports, including comparison on key measures, to birthing facilities quarterly and include technical assistance comments.

Strengthen technical assistance and training support to the Early Head Start grantees serving newborns, infants and toddlers through the Hearing Head Start project.

Expand training and technical assistance to primary health care practices to conduct otoacoustic emissions (OAE) screening using the Hear and Now curriculum developed by National Center for Hearing Assessment and Management.

Continue training birthing facility staff to reduce the number of infants who are lost to follow-up.

In partnership with the University of Nebraska-Lincoln and Nebraska Association for the Education of Young Children, continue expansion of the Nebraska Children's Hearing Aid Loaner Bank for young children recently identified with a permanent hearing loss.

Continue implementation of the single point of entry for parents of children recently identified with a hearing loss in partnership with the Early Development Network (Part C) and other partners.

Develop a website for the Early Hearing Detection and Intervention Program.

Conduct a parent weekend workshop for parents of young children recently identified.

c. Plan for the Coming Year

With the benchmark of 95% of newborns screened during birth admission having been consistently met, program activities for calendar year 2010 will continue to focus on implementing the ongoing mandates of Nebraska's Infant Hearing Act: expansion, enhancement and maintenance of the reporting and tracking system, collection of required data, application for federal funding, and providing consumer and professional education. The goals and objectives identified in the federal funding applications (HRSA/MCHB and CDC/NCBDDD/EHDI) will be implemented to further develop the screening, diagnostic and services systems; expand the reporting and tracking system, linkage with other child data systems; and refine the quality assurance mechanisms.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	5.5	12.2	11.3	12.3	13.6
Annual Indicator	12.4	11.5	12.6	13.9	16.2
Numerator	18000	18000	19000	22000	24000
Denominator	145000	156000	151000	158000	148000
Data Source					Census
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	15.9	15.6	15.2	14.9	14.6

a. Last Year's Accomplishments

The Department of Health and Human Services Division of Medicaid and Long-Term Care contracted with Mercer Health Government Human Services Consulting services provided by Mercer Health & Benefits LLC, to assist in developing a series of reports related to Title XXI. Similar to other states, program expenditures for Medicaid (Title XIX) and the State Children's Health Insurance Plan (Title XXI) in Nebraska continue to increase. In an effort to ensure long-

term savings and program stability for the Title XXI program, the legislature recognized the necessity for studying and developing recommendations relating to the provision of health care and related services for Medicaid-eligible children under the state children's health insurance program as allowed under Title XIX and Title XXI of the federal Social Security Act. The study and recommendations included, but were not limited to the organization and administration of the program; the establishment of premiums, copayments and deductibles; and the establishment of limits on the amount , scope and duration of services offered to recipients. An initial report was presented to the Medicaid Reform Council and the Health and Human Services Committee of the Legislature on October 1, 2007. The final written report prepared under contract with Mercer, presented to the Governor, Medicaid Reform Council and Health and Human Services Committee of Legislature on December 1, 2007, recommended that the state convert its current Medicaid expansion State Children's Health Insurance Program (CHIP) into a separate stand-alone State Children's Health Insurance Program (SCHIP). This option provides the maximum flexibility to the State for administering its Title XXI program. Four scenarios for cost sharing and administration of the SCHIP were outlined in the final report. The final report is available at http://www.dhhs.ne.gov/med/reform/.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MHCP continued to provide/pay for limited specialty services for CSHCN within available resources.	X			
2. Gap filling services provided through FQHCs, Indian Health Services facilities, and an ever-growing number of community-based "free clinics."	X			
3. Policy makers received and reviewed report of options under Title XXI, Title XIX, and the DRA, guiding possible legislatie and administrative actions related to insurance coverage for children.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During the 2009 legislative session, LB 603 was passed and signed into law. This bill encompassed a number of child health and wellbeing provisions, particularly related to behavioral health. But it also included an expansion of Medicaid/SCHIP coverage by increasing income eligibility for children to 200% of poverty, from the previous level of 185%. This change goes into effect later this summer. Nebraska SCHIP continues to be a Medicaid expansion.

c. Plan for the Coming Year

Expanded income eligibility for Medicaid will be in place during FFY 2010, and hopefully will reverse or slow down the trend of increasing numbers of children without health insurance.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			32	31.4	33.7
Annual Indicator		32.9	33.5	34.4	36.4
Numerator		4848	5036	5263	6204
Denominator		14724	15028	15311	17034
Data Source					NE WIC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	35.7	35	324.3	33.6	32.9

a. Last Year's Accomplishments
The Nebraska WIC Program participated in Community Nutrition Partnership Council to collaborate on SNAC plan promotion action steps including distributing Pick a Better Snack and Fruits and Veggies More Matters materials for use in all WIC local agencies.

Lifespan Health Services Unit formed a workgroup was to conduct problem analyses and develop strategies to address the priority need of healthy weight among women of childbearing age and children. During FFY 2007, preliminary data analysis and literature reviews were conducted, and the work group began its deliberations. Workgroup members included stakeholders from the WIC Program, as well as Title V/MCH supported projects and other interested organizations. This Healthy Weight Workgroup completed its strategy development activities in FFY 2008. Three logic models were developed around 3 problem statements and associated theories of change. These Logic Models were incorporated into the Request for Applications for MCH community based projects issued in May 2008. Applications were received the week of July 1, 2008. Awards were made for a 3 year period beginning October 1, 2008, for the following relevant projects.

Four Corners Health Department: Partner with communities to promote healthy weight among children. Implement Animal Trackers curriculum in daycares/preschools. Animal Trackers increases structured physical activity time during the preschool day. Host Family Fun Nights to support families in physical activity and healthy eating. Enhance current activities, e.g. Concordia University's Early Childhood Education Conference, and Seward Family Fun Night. Contract with Registered Dietitian to reach families through farmers' markets and immunization clinic.

Lincoln/Lancaster County Health Department: Implement "A Family Approach to Prevention of Childhood Obesity" in three census tracts of Lincoln with a 34% minority population, > 25% of population is < 18 years of age, and with a high rate of poverty. Convene community partners and resources to pilot "54321 GO" project (participants focus on achieving 5 servings of fruits and vegetables, 4 servings of water, 3 servings, of low-fat dairy products, 2 hours or less of screen time, and 1 hour or more of physical activity each day) and evaluate effectiveness of this approach.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Planned and implemented an educational initiative for WIC families focused on fruit and vegetable consumption and healthy snacks.			X	
2. Participated in the Community Nutrition Partnership Coundil to collaborate and coordinate USDA State Nutrition Action Plan (SNAP) activities.				X
3. Title V supported work group developed priority strategies to address overweight among women and children; strategy logic models incorporated into Title V RFA for community based services.				X
4. Two community based projects selected and funded by Title V to carry out nutrition/physical activity projects targeting at risk children.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The current five-year nutrition goal selected to be worked on by the state WIC agency and all Local WIC agencies is related to decreasing the rate of childhood overweight and obesity; By August 1, 2013 reduce the percentage of Nebraska WIC children ages 2-4 that are at or above the 85th percentile BMI-for-age. Strategies for this goal are: Using a family feeding dynamics approach to provide nutrition education and encourage family lifestyle behaviors that increase physical activity. In April 2009, 120 WIC nurses and nutrition staff attended a two-day training session on family-feeding dynamics with emphasis on division of responsibility in feeding, eating competence, and strategies for WIC to work with clients to promote healthy weight in children.

The Title V funded projects promoting healthy weights among young children continue.

c. Plan for the Coming Year

The WIC Program will continue to participate in activities of the SNAC plan for USDA programs and participate in bi-annual meetings of the Community Nutrition Partnership Council. The WIC Program will also continue work on action steps of the five-year goal to reduce the percentage of WIC children ages 2-4 that are at or above the 85th percentile BMI-for-age. In April 2010, WIC staff attending the WIC/CSFP meeting will have the opportunity to attend sessions focusing on action steps for this goal. The WIC Nutrition Coordinator will collaborate as part of the Nutrition and Activity for Health Program on physical activity promotion for preschool age children. The WIC program will implement nutrition education activities targeted at behaviors related to childhood overweight such as limiting consumption of sugar sweetened beverages, and encouraging family meals.

On October 1, 2009 the WIC food package will change. Part of this change includes the

requirement to provided reduced fat or low-fat milk for children 2-4 years of age and women. The change also brings the WIC food package closer to the dietary guidelines by providing food packages that include fresh fruits and vegetables and whole grains.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			11.9	11.7	11.3
Annual Indicator		12.2	11.8	11.6	11.8
Numerator		3186	3148	3122	3106
Denominator		26143	26629	26935	26404
Data Source					Birth file
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	11.5	11.3	11.1	10.8	10.6

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births).

a. Last Year's Accomplishments
Lifespan Health Services staff and Tobacco Free Nebraska staff developed a promotional plan of new activities to increase tobacco cessation of pregnant women. Educational materials were updated and a new order form developed. A letter encouraging health care providers to discuss the importance of tobacco cessation for pregnant women, and a description of resource materials available was sent. The "Quit Now" television ad aired the week of Mother's Day week about the danger of tobacco and secondhand smoke for women.

The Nebraska legislature appropriated $500,000 state general funds to cover the costs of tobacco use cessation counseling and tobacco use cessation pharmaceuticals for adult Medicaid eligibles. It was estimated that 3% of the adult Medicaid population would seek smoking cessation assistance each year, and this includes pregnant women. This service began December 1, 2008. See Current Activities below.

School districts who received TFN/School and Child Health Program awards developed and delivered prevention activities during the 2007-08 school year.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintained, promoted, and distributed perinatal tobacco cessation materials to health care providers and community organizations.			X	

2. School nurses implemented tobacco cessation activities wihtin NE schools.			X	
3. Continued collaborations with Tobacco Free Nebraska, including updating promotional materials and airing a 30 second PSA focused on tobacco cessation for women of childbearing age.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Beginning December 10, 2008 Nebraska Medicaid covers counseling and certain drugs specifically approved to help clients quit using tobacco. In order for a Medicaid client to be eligible to receive Medicaid coverage of the drug product, the client must be at least 18 years of age and must be enrolled and actively participating in the Tobacco Free Quitline. There is a special protocol for pregnant women enrolled in the Medicaid program. Pregnant women do not received medication, but have unlimited use of the Tobacco Free Quitline, and may access the tobacco cessation counseling visits.

The Nebraska Clean Indoor Air Act went into effect on June 1, 2009 and requires indoor workplaces in Nebraska to be smoke-free. The purpose of the Act is to protect the public health and welfare by prohibiting smoking in public places and places of employment.

The Act eliminates smoking in enclosed indoor workspaces including restaurants, bars, keno establishments, other workplaces (retail/office space, manufacturing, etc.) and indoor public places.

More information about this act can be found at: http://smokefree.ne.gov/

Lifespan Health Services supports these activities in the Nebraska Tobacco Free Program; staff continues to provide tobacco cessation resource materials to providers at no cost.

c. Plan for the Coming Year
Nebraska Title V and TFN will continue long-standing collaborations to promote tobacco prevention and cessation within the MCH populations. New initiatives will be developed as resources permit.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2004	2005	2006	2007	2008

Data					
Annual Performance Objective	8	7.5	13.4	13.1	12.8
Annual Indicator	11.6	13.7	16.1	11.5	13.2
Numerator	15	18	21	15	17
Denominator	129578	131107	130338	130506	128885
Data Source					Death file, Census Est.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12.9	12.6	12.4	12.1	11.9

Notes - 2007
2007 Death file is incomplete, missing out of state deaths and few thousand causes of death.

I have switched to a three year rolling average based on reviewer recommendation.

a. Last Year's Accomplishments
The Suicide Prevention Coalition conducted training sessions toward the implementation of the LOSS (Local Outreach to Suicide Survivors) program. This program brings immediate support to survivors as close to the time of death as possible. Training was also done with local law enforcement to plan for implementation. Several schools interested in implementing Teen Screen were identified. A barrier had been permission from local school boards. The Suicide Coalition worked with these communities. The SOS (Signs of Suicide) Program, a school-based suicide prevention program, was implemented in the Lincoln Public School System. Training was conducted in June, 2008. Don Belau, Ph.D., co-chair of the Suicide Coalition, conducted a community presentation "Recognizing & Responding to Threats of Adolescent Self-Harm" at Bryan LGH in June 2008. The program was very well attended and well-received.

At the annual statewide school health conference, participants identified adolescent suicide and intentional self-injury as priority concerns and requested additional continuing education opportunities be developed on this topic. Subsequently, the coalition invited the State School Nurse Consultant, Lifespan Health Services Unit, to join the coalition to help explore successful strategies to reach youth and educators.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implemented LOSS support for survivors project and provided training in selected sites.			X	
2. Signs of Suicide (SOS) implemented in 1 school.			X	
3. Training events and presentations on suicide prevention provided in coordination with other stakeholders, to increase awareness of topic and to further collaborative efforts.			X	
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Several schools have begun implementation of the SOS (Signs of Suicide) program. A related presentation was made by a local expert through the TESH (Telehealth Education for School Health) project. Participants joined the session from over 22 local health departments and other health facilities. Peer-approved contact hours were awarded to nurse participants. The ession title was Adolescent Self-Injury and Suicide: a Continuum of Disaster. Then, this expert also presented at the 25th annual statewide school health conference on the topic of Self-Injury and Suicide Assessment and Interventions.

Subsequently, the Statewide Suicide Prevention Coalition has invited educational leaders to attend a recent monthly meeting, for a special agenda focusing on adolescent suicide and working successfully with schools. The objective was to broaden the range of possible interventions and supports the coalition could offer those who work with schools and youth, beyond standard classroom curricula. Recommendations included placing a greater emphasis on the availability of on-line professional development resources for teachers on youth suicide risk and intervention.

The Nebraska Suicide Prevention Coalition has continued efforts to implement of the LOSS (Local Outreach to Suicide Survivors) Program. July 1 has been set as the target date for implementation of this postvention program. Two communities were awarded minigants to conduct community suicide prevention activities.

c. Plan for the Coming Year

The Suicide Prevention Coalition worked with the Nebraska Division of Behavioral Health, the Injury Prevention Program, and the University of Nebraska Public Policy Center to aply for SAHMSA funding for youth suicide prevention. The funding, if received, will provide for youth suicide prevention activities in communities around the state.

The continued involvement of the school nurse consultant willprovide an opportunity to continue reaching and involving school health professionals with resources and information.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	90	74.3	78.2	73.7	69.2
Annual Indicator	75.2	74.6	71.9	68.1	68.5
Numerator	279	217	218	220	207
Denominator	371	291	303	323	302
Data Source					Birth file
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year,					

and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	69.8	71.2	72.7	74.1	75.6

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births).

Notes - 2006
Targets have been reset

a. Last Year's Accomplishments
All UNMC/UNO Master of Public Health Program students must complete a service learning capstone project. In 2007, a student completed her capstone project that focused on Nebraska's perinatal system. The project produced a description of the current status of regionalized perinatal services in Nebraska. Specifically, there were two parts to the project. The first was a literature review of the historical and current status of perinatal regionalization nationally. Essential background for this part was the national Guidelines for Perinatal Care, Fifth Addition, American Academy of Pediatrics and The American College of Obsetricians and Gynecologists, for definitions of and guidelines for levels of care, supplemented with current research and position papers on perinatal regionalization. Next was an in depth examination of the current Nebraska system. With the guidance of Lifespan Health Services staff and others, the student gathered information from applicable DHHS programs such as Medicaid, from Nebraska hospitals, and from Nebraska health care provider organizations. This capstone project provided a detailed description of the current status of perinatal regionalization in Nebraska.

During 2008, a second College of Public Health student continued work on levels of care as her Capstone project. Using the data gathered in 2007, the second student 1) Examined the distribution of births in Nebraska over a 5-10 year time period according to hospital level of care criteria (3 groups categorized by level of maternity and neonatal care services); 2) Examined the distribution of low birth weight and very low birth weight births in Nebraska over a 5-10 year time period according to hospital level of care criteria; and 3) Examined the distribution of low birth weight babies born in level I and II hospitals that are transferred for care according to the birth certificate data. The public health questions explored included: should hospital administration recommend referring mothers with infants at risk for low birth weight to level II and III hospitals for delivery and neonatal care? Who should be referred and when?

Among conclusions of this research were that: 61.4% of LBW, VLBW and ELBW infants were born in level 3 facilities compared to 40.2% of NBW infants; 2.7% of all births and 15.5% of LBW births were transferred either pre- or post-natally; the majority of the LBW infants were transferred to hospital level of care 3 (79.18%) compared to hospital level of care 2 (8.75%); among infant deaths, 8.2% had a maternal transfer as opposed to 0.6% of surviving infants; about 75.9% of the total infant deaths occurred in situations where neither mother nor infant was transferred; and insulin-dependent diabetes, uterine bleeding and genital herpes were the main factors associated with maternal (prenatal) and/or newborn transfer.

Preleminary conclusions included a possible need for providers to perform more systematic risk assessment regarding the need for prenatal transfers. Further research is necessary to examine whether mortaltiy results differ for neonatal deaths versus the alrger category of infant deaths.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Completed analysis of data related to location of delivery, transport of mothers and infants, and infant outcomes, for future policy development related to transport and/or regionalization.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Further action on the findings of the student's research are pending.

A somewhat related activity has been a re-assignment of duties to our 3 Community Health Nurses located in field offices across these states. In addition to their usual Immunization Program duties, these nurses will be working with Nebraska birthing hospitals to provide information and technical assistance on a wide range of perinatal health issues. A 4th Community Health Nurse position is currently vacant, and a nurse with perinatal health experience is being recruited to assume leadership for working with birthing hospitals and other providers comprising Nebraska's perinatal health system.

c. Plan for the Coming Year
With a perinatal health nurse specialist on staff, Lifespan Health Services hopes to re-focus on working with Nebraska's birthing hospitals on a wide range of issues, including levels of care and other aspects of perinatal guidelines.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	90	84.6	79.3	80.9	74.8
Annual Indicator	82.7	77.8	71.5	73.2	72.2
Numerator	21773	20332	19096	19721	19051
Denominator	26323	26144	26723	26935	26404
Data Source					Birth file
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	73.6	75.1	76.6	78.1	79.7

Notes - 2007

Out of state resident births are not yet in the data file (1000+ births). Over 2% of the data for this PM is missing/unknown.

Notes - 2006
Over 5% of the data for this PM is missing/unknown.

a. Last Year's Accomplishments
Beginning in 2005, TANF funds were earmarked to fund a pilot project to provide referral and supportive services to women who are pregnant or believe they might be pregnant. These funds, administered by the Lifespan Health Services, were competitively awarded to one grantee. Through 2007, this grantee implemented outreach strategies for the project titled "Positive Alternatives" and made referrals to its network of subcontractors, including referrals to prenatal care providers and other services for women and their families. The funding was continued into 2008 and 2009, and a new provider in a different community was identified through a competitive process. This project, titled Well Mothers, Welcome babies, continues to work with women, assisting them in accessing prenatal care.

MCH/CSHCN Strategic Planning Workgroup that addressed preterm births and very low birth weight outlined strategies that focused on pre and interconception health care. Thus the emphasis on reaching women even before pregnancy continued. These strategies were incorporated into the RFA for community-based MCH projects issued in May 2008. One of the seleted projects included enhanced family planning visits with preconception risk assessment and reproductive health plan. This project also seeks to increase access to early prenatal through the use of a community-based Care Line and referral to physicians. A prenatal care project was also selected that expanded its scope of services to include pre- and interconception care.

In addition, Lifespan Health Services submitted an application for the First Time Motherhood/New Parents Initiative grant. The application focused on messaging to women 15-24 who are uninsured or at risk of being uninsured. The application was funded for a two year period, beginning September 2008.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided title V financial support to prenatal and preconception care through community based programs.	X	X	X	
2. Continued promotion of Healthy Mothers, Healthy Babies helpline.			X	
3. Administered TANF funded program for supportive services for pregnant women and women who believe they may be pregnant.		X	X	
4.				
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
Lifespan Health Services continues to develop pre and interconception health strategies. Women who are well informed, have reproductive life plans, and are engaged in taking care of their own health will be more likely to recognize the importance of prenatal care when they do become pregnant, and to seek out those services. They will also be more likely to have better health status as they enter pregnancy, compensating somewhat for a later entry into care should they have difficulty accessing care in the first trimester.

In regards to access, the increase in income eligibility authorized in LB 603 does not apply to pregnant women. Lifespan Health Services continues its collaboration with FQHCs and other safety net providers. Limited Title V funds are available for prenatal care.

The TANF funded project, Well Mothers, Welcome Babies continues.

The First Time Motherhood/New Parents Initiative is underway, with lifecourse health/preconception health messages being developed and tested with women ages 16-25.

The Infant Mortality Disparity Work Group is currently meeting, and has examined a range of factors impacting disparate outcomes. Though prenatal care has not been a focus of the work group's deliberations, related community factors are being considered.

c. Plan for the Coming Year
The First Time Motherhood/New Parents Initiative funded project will be in its second year. Activities will include training for providers (health, human service, education, and faith based) on a lifecourse model of preconception health. In addition, funds will be awarded competitively to communities seeking to incorporate preconception health promotion and related services.

The Infant Mortality Disparity Work Group will conclude its deliberations, making recommendations for prioritzed strategies. As feasible, selected strategies will be imlemented.

The impact of LB 403 on prenatal care access will be monitored.

D. State Performance Measures

State Performance Measure 1: *Percent women (18-44) with healthy weight (BMI)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			52.6	53.6	54.2
Annual Indicator		51.6	49.9	54	53.5
Numerator					
Denominator					
Data Source					NE BRFSS
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	54.6	55.6	56.7	57.9	59

Notes - 2008
2008 NE BRFSS, weighted data.

Notes - 2007
2007 NE BRFSS, weighted data.

Notes - 2006
2006 NE BRFSS, weighted data.

a. Last Year's Accomplishments
The Nebraska/Douglas County learning collaborative team was formed in 2006. The team consisted of local representatives of chronic disease, WIC, and a community based preconception health program, an assistant professor of the School of Health Physical Education and Recreation, University of NE, as well as state MCH and chronic disease professionals. The Nebraska team developed vision, goals and opportunities for action. The team's main strategy is to expand an existing preconception program and integrate with a pre-existing social support group for women that focuses on behavior change. Focus groups were initiated in August, 2007. The second on-sight meeting of the ALC occurred in June, 2007 in which the teams focused on message development and evaluation. In FY 2008, this learning collaborative team analyzed and incorporated the focus group findings to re-tool the social support group while working with the preconception programs/agencies to refer women to the group. A pilot support group was launched. The team met for the third time in December, 2007 to focus on evaluation and reporting.

In FY 2007, the Office of Women's Health launched a project funded under the "Innovative Approaches to Promoting a Healthy Weight in Women" initiative. This three year project focuses on community-based interventions in both a rural and an urban settings. In FY 2008, the project was fully implemented. Evaluation data was collected on the impact on health status and behaviors of women participating in the two sites.

The Health Promotion Unit received a grant award from the CDC for Nutrition, Physical Activity, and Obesity Prevention. This 5-year, $726,953 per year grant will substantively build Nebraska's capacity to develop and support comprehensive nutrition and physical activity efforts, including those for the women of reproductive age. The State Plan details the development and enhancement of supports within communities, schools and child care facilities, worksites and health care systems to improve environments, policies, and social supports for healthy eating and physical activity.

The MCH/CSHCN Strategic Planning Workgroup developed logic models focused on women of reproductive age. These logic models were incorporated into the RFA for community-based MCH projects. Two projects were funded with nutrition and physical activity components addressing women of reproductive age. Two additional projects address broader goals related to preconception health, but relevant to this performance measure.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participated in the MCHP/CityMatCH Healthy Weight Action Learning Collaborative, and used experience in planning NE interventions.				X
2. Implemented actviites under "Innovative Approaches to Promoting a Healthy Weight in Women" grant.	X		X	
3. Healthy Weight work group (MCH/CSHCN strategic planning				X

process) completed logic model and action plan for priority strategies.				
4. Logic models from Healthy Weight work group incorporated into RFA for Title V supported community based projects. Four projects were selected that directly and indirectly address healthy weight among women.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Lifespan Health Services continues to collaborate with the Health Promotion Unit in implementing the Nutrition, Physical Activity, and Obesity Prevention grant project. The Innovative Approaches to Healthy Weight in Women Project continues. The First Time Motherhood/New Parents Initiative has yielded information on messages for women ages 16 - 25 which will be useful for healthy weight campaigns. The 4 community-based projects funded in 2008 continue.

c. Plan for the Coming Year
The First Time Motherhood/New Parents Initiative project will produce resources for providers to enhance preconception health messages to women ages 16-25, including messages related to healthy weight. The community-based Title V projects will continue. The Innovative Approaches to Healthy Weight in Women will be in its final year.

State Performance Measure 2: *Percent of women of child-bearing age who report smoking in the last 30 days*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	19	19.3	17.5	21.4	19.1
Annual Indicator	21.1	25.4	21.9	19.5	20.3
Numerator	68369				
Denominator	324598				
Data Source					NE BRFSS
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	19.9	19.5	19.1	19.7	18.3

Notes - 2008
2008 NE BRFSS, weighted data.

Notes - 2007
20067 NE BRFSS, weighted data.

Notes - 2006
2006 NE BRFSS, weighted data.
Targets have been reset to 2% imprvement rather than HP2010.

a. Last Year's Accomplishments

Lifespan Health Services staff and Tobacco Free Nebraska staff developed a promotional plan of new activities to increase tobacco cessation of pregnant women. Educational materials were updated and a new order form developed. A letter encouraging health care providers to discuss the importance of tobacco cessation for pregnant women, and a description of resource materials available was sent. The "Quit Now" television ad aired the week of Mother's Day week about the danger of tobacco and secondhand smoke for women.

The Nebraska legislature appropriated $500,000 state general funds to cover the costs of tobacco use cessation counseling and tobacco use cessation pharmaceuticals for adult Medicaid eligibles. It was estimated that 3% of the adult Medicaid population would seek smoking cessation assistance each year, and this includes pregnant women. This service began December 1, 2008. See Current Activities below.

School districts who received TFN/School and Child Health Program awards developed and delivered prevention activities during the 2007-08 school year.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintained, promoted, and distributed perinatal tobacco cessation materials to health care providers and community organizations.			X	
2. Continued collaborations with Tobacco Free Nebraska, including completion of school nurse tobacco prevention education project.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Beginning December 10, 2008 Nebraska Medicaid covers counseling and certain drugs specifically approved to help clients quit using tobacco. In order for a Medicaid client to be eligible to receive Medicaid coverage of the drug product, the client must be at least 18 years of age and must be enrolled and actively participating in the Tobacco Free Quitline. There is a special protocol for pregnant women enrolled in the Medicaid program. Pregnant women do not receive medication, but have unlimited use of the Tobacco Free Quitline, and may access the tobacco cessation counseling visits.

The Nebraska Clean Indoor Air Act went into effect on June 1, 2009 and requires indoor workplaces in Nebraska to be smoke-free. The purpose of the Act is to protect the public health and welfare by prohibiting smoking in public places and places of employment. The Act eliminates smoking in enclosed indoor workspaces including restaurants, bars, keno establishments, other workplaces (retail/office space, manufacturing, etc.) and indoor public places. More information about this act can be found at: http://smokefree.ne.gov/

Lifespan Health Services continues to collaborate with the Nebraska Tobacco Free Program and provides tobacco cessation resource materials to providers at no cost.

c. Plan for the Coming Year
Nebraska Title V and TFN will continue long-standing collaborations to promote tobacco prevention and cessation within the MCH populations. New initiatives will be developed as resources permit.

State Performance Measure 3: *Percent of women age (18-44) who report mental health not good 10+ days of past 30*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			10.1	13.2	12.9
Annual Indicator		10.3	13.5	13.1	10.8
Numerator					
Denominator					
Data Source					NE BRFSS
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10.5	10.3	10.1	9.9	9.7

Notes - 2008
2008 weighted data

Notes - 2007
2007 NE BRFSS, weighted data.

Notes - 2006
2005 NE BRFSS, weighted data.

a. Last Year's Accomplishments
The work products of the Perinatal Depression Project that were completed during 2007 were maintained. Resources for women and their families include: brochures in English and Spanish; posters in English and Spanish; web site www.dhhs.ne.gov/MomsReachOut; and a traveling exhibit. Provider resources include: web site www.dhhs.ne.gov/Perinatal Depression; interactive curriculum for continuing education for mental health practitioners, nurses and physicians; toolkit; a traveling exhibit; and brochures and posters.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Maintained resources developed through Perinatal Depression project, including web sites, provider curriculum, and public information materials.			X	
2.				
3.				

4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Perinatal Depression Project materials and on-line resources have been maintained. The Women's Health Council has a task force currently examining ways to further advance efforts to improve screening, referral and treatment of perinatal depression.

The First Time Motherhood/New Parents Intiative project is yielding information related to stress and social/emotional status of young women ages 16 - 25. The social marketing contractor is currently developing messages relevant to these issues.

The Project LAUNCH application submitted to SAMHSA includes perinatal depression activities. Status of that application are still unknown.

Comments received regarding the development of this Title V application have included those stressing the challenges in meeting the mental health needs of the MCH population.

c. Plan for the Coming Year
With the Women's Health Council and other stakeholders, further collaborative planning is needed to address the gaps and barriers to mental health services for women and children. Of particular concern is the fact that women identified with mental health needs during pregnancy lose their Medicaid eligibility early in the post partum period. Identifying community resources for these women will require particular attention.

Messages will be developed for young women, and training will be provided to providers as part of the First Time Motherhood/New Parents Initiative project. Managing stress and developing healthy relationships are health concerns of young women and will be incorporated into the preconception health messages. Planning for a future pregnancy and child rearing is difficult if a woman's current social/emotional status is less than optimum.

State Performance Measure 4: *Percent of teens who report use of alcohol in last 30 days*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	58	45.6	42	41.2	40.1
Annual Indicator	46.5	42.9	42.9	41.1	41.1
Numerator	60855				
Denominator	130871				
Data Source					NE YRBS
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	39.3	38.5	37.7	36.9	36.2

Notes - 2008

2007 YRBS did not achieve an adequate response rate. YRBS is conducted every two years.

Notes - 2007
2007 YRBS did not achieve an adequate response rate.

Notes - 2006
2005 YRBS is a weighted survey. YRBS is conducted bi-annually.

a. Last Year's Accomplishments
The Adolescent Health Program within Lifespan Health Services continued the work of NE Partnerships for Positive Youth Development through the promotion and advocacy of the principles of positive youth development. A focus was placed on the risk and protective factors associated with underage drinking and other adolescent risk behaviors resulting in negative outcomes for this population. Education was provided to local coalitions, youth serving groups, stakeholders and partners of the important of reducing the risk factors as well as advocating youth development as the foundation for all prevention efforts. Presentations were made to various groups including the state's Family and Consumer Science Teachers as well as those groups focusing on reducing teen pregnancy. Identifying evidence-based practices that incorporate youth development concepts was an outcome of a task force addressing teen pregnancy. Participation continued on the task force working to implement the YRBS, YTS and NRPFSS with the goal of conducting a combined survey effort within school districts in the fall of 2010. The second edition of Nebraska Adolescents, Keeping Them Healthy, which highlighted and compared the state's YRBS results and identified risk factors across multiple health issues, was completed and issued through a collaborative effort with the Department of Education.

Nebraska's Strategic Prevention Framework, State Incentive Grant (SPF SIG) issued its strategic plan in March 2008. Three alcohol-related priorities iwere dentified in this plan: 1) Prevent alcohol use among persons 17 and younger; 2) Reduce binge drinking among 18-25 year olds; and 3) Reduce alcohol impaired driving across all age groups. SPF SIG also completed the process of issuing a Request for Applications to fund projects at the community level. Funding source is the federal Substance Abuse Mental Health Services Administration. Selected projects that addressed the three priorities identified by the state were in place among sixteen (16) state organizations. Applicants were required to incorporate evidence-based strategies as well as address the risk and protective factors associated with alcohol use among adolescents.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued to develop and promote NE Partnerships for Positive Youth Development.			X	X
2. Strategic Prevention Framework State Incentive Grant (SPF/SIG) project completed development of strategic plan; adolescent alcohol use one of 3 priorities.				X
3. SPF/SIG project funded 16 community based projects, with most addressing youth alcohol prevention.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Adolescent Health Program launched an Adolescent Comprehensive Systems initiative patterned from the Early Childhood Comprehensive Systems (ECCS) project. Supported by mini grant funds from AMCHP, stakeholders and staff within the Department were convened to begin identifying the components of a comprehensive system for this population.

Education specific to risk and protective factors associated with all risk behaviors and outcomes was provided to numerous groups including the state's Head Start Conference, a tele-health session provided to school nurses and as a roundtable contributor at a statewide Dropout Summit. The Adolescent Health Program is one of several partners collaborating with the Department of Education in launching a Coordinated School Health initiative across the state.

SPF SIG developed supportive materials for local projects including an implementation tool kit that assists local grantees to successfully implement their SPF SIG strategic plans. A strategy approval guide was also developed The guide describes population level behavior change theory, criteria to help determine if a strategy is a good fit for the community, a set of strategies that are pre-approved for SPF SIG communities, and the process for seeking approval of stratetegies. Nine additional communities were awarded grants for substance abuse prevention activities primarily among school-aged youth. Source of funding for this activity is the Safe & Drug Free Schools Program.

c. Plan for the Coming Year
The Adolescent Health Program plans to continue the development and refinement of the Adolescent Comprehensive Systems Initiative on an on-going basis. Strategies for addressing the selected outcomes and indicators will be identified and appropriate action steps put in place. Work groups for each of the identified system components will be recruited and operationalized. The program will continue to collaborate with the SPF SIG activities including the implementation of the Nebraska Youth Risk and Protective Factor Student Survey (NYRPFSS), the Youth Risk Behavior Survey (YRBS) and the Youth Tobacco Survey (YTS). The program will participate in an on-going Coordinated School Health training cadre providing implementation training and instruction to selected school districts across the state.

SPF SIG will carry out action steps in accordance with its strategic plan, and will be in the full implementation phase of the project. Technical assistance as well as tools and materials will be made available to all grant recipients. Special emphasis will be given to assessment, coalition building and effectiveness, evaluation, cultural competency, and sustainability.

State Performance Measure 5: *Percent premature births (births<37 weeks)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			8.7	9.8	9.6
Annual Indicator		9.8	10.0	9.6	9.7
Numerator		2566	2676	2584	2555
Denominator		26144	26723	26935	26404
Data Source					Birth file
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	9.8	9.3	9.1	8.9	8.8

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births).

a. Last Year's Accomplishments
The Preterm/Low Birth Weight Work Group completed its review of the literature and data, then reviewed evidence based interventions for the prevention of preterm/low birthweight. Three logic models were developed, each addressing a range of life course approaches including pre and interconception health. These logic models were incorporated into the RFA for community-based MCH projects, issued May 2008. Applications were received the week of July 1, 2008 and awards were made for a 3-year period that begins in FFY 2009.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Community based initiatives including Northern Plains Healthy Start, Omaha Healthy Start, and Omaha Baby Blossoms continued targeted activities and projects.			X	X
2. Preterm birth/LBW work group (MCH/CSHCN strategic planning process) completed logic model and action plan; incorporated into RFA for community based projects. Four related projects selected and funded.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Three of the community-based projects selected through the competitive process in 2008 have as a selected goal the reduction of preterm births/low birth weight. All three are addressing this goal through preconception/interconception strategies.

A contract was executed with the Douglas County Health Department to develop local capacity to address preconception health as a strategy to reduce rates of preterm birth and infant mortaltiy.

The First Time Motherhood/New Parents Initiative is underway, and will further build our capacity to impact preconception health within a lifecourse health development model.

The Infant Mortality Disparity work group formed in 2009 is also addressing preterm birth related factors.

c. Plan for the Coming Year
Nebraska Title V will continue its emphasis on a lifecourse health development model. Year Two of the First Time Motherhood/New Parents Initiative will see the roll out of informational campaigns for young women ages 16-25, education for provider groups to better promote preconception health, and subgrants to selected communities to support life course/preconception health programming.

State Performance Measure 6: *Rate of infant death to adolescents (age 15-17)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			7.7	7.5	7.4
Annual Indicator	14.9	8.7	8.1	7.3	
Numerator	10	6	5	5	
Denominator	670	690	616	687	
Data Source					Linked Birth and Death file
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7.2	7	6.9	6.7	6.6

Notes - 2008
Data not yet available.

Notes - 2007
Data not yet available.

Notes - 2006
Data not yet available.

a. Last Year's Accomplishments
The collaborative work among Protection and Safety, Title V/MCH, and Medicaid in regards to home visitation for at-risk families, including pregnant teens, continued. Expectations for evidence-based home visitation models were developed and incorporated into a Request for Bids for home visitation for families at-risk for child abuse and neglect and contracts were awarded.

The Preterm Birth/Low Birthweight Work Group logic models were incorporated into the RFA for community-based MCH projects. Four of the selected projects incorporate preconception/life course strategies with the potential for postively impacting adolescents and their health behaviors and outcomes.

A TANF supprted project serving women who are pregnant or believe they are pregant provided supportive services to women, including adolescents, in one community.

The First Time Motherhood/New Parents Initiative Grant application was prepared with a particular emphasis on adolescents through young adulthood (ages 16-25).

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Risk reduction activities carried out by Reproductive Health Program and Abstinence Education, and through positive youth development			X	
2. Prenatal care project funded through Title V provided clinical and enabling services to pregnant adolescents.	X	X		
3. Administered TANF fuded pregnancy support project.			X	
4. Collaborated with Protection and Safety on home visitation programs.		X		X
5. Preterm birth/LBW logic models incorporated into Title V RFA			X	

for community based services; four selected and funded projects addressing preconception health for at risk populations including adolescents.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The four Title V funded community based projects continue to provide preconception/interconception services to women of reproductive age, including adolescents. The First Time Motherhood/New Parents Initiative Project has completed focus group interviews with young women ages 16-25, providing insight into their health behaviors and beliefs. Message development and communication strategies are currently being developed by the contractor.

The TANF supported project continues. The Adolescent Health program is developing a comprehensive systems model for adolescent health, similar to that that has guided the Early Childhood Comprehensive Systems project. This model, when fully developed, will provide an integrated framework to address a range of healthy outcomes for adolscents.

c. Plan for the Coming Year
Lifespan Health Services and its Adolescent Health Program will continue to develop a collaborative model for adolescent health. Work will continue to promote and support Coordinated School Health. The Reproductive Health Program will continue its social marketing efforts, including ways to improve services for adolescents.

State Performance Measure 7: *Incidence of confirmed SIDS cases (per 1,000 live births) among African American and Native American infants*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	2.2	2.5	2.7	2.6	2.3
Annual Indicator	2.8	3.0	2.7	2.4	2.6
Numerator	26	29	27	25	28
Denominator	9325	9579	9960	10446	10657
Data Source					Death file, Birth file
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2.3	2.3	2.3	2.3	2.3

Notes - 2008
2008 Death file is incomplete, missing out of state deaths and few thousand causes of death. Because numbers are so small this is (and has been) a 5 year average.

Notes - 2007
2007 Death file is incomplete, missing out of state deaths and few thousand causes of death. Because numbers are so small this is (and has been) a 5 year average.

Notes - 2006
Because numbers are so small this is (and has been) a 5 year average

a. Last Year's Accomplishments

Through the efforts of Baby Blossoms, an Omaha area collaborative, a vigorous safe sleep campaign has been in place in Douglas County for a number of years. The Douglas County Health Department facilitated efforts that included development of curricula for health care and child care providers, educational materials, and public awareness events. During FFY 2008, a surge in the number of sleep-associated deaths in which the infant was sharing a bed with another person resulted in intensified educational efforts on the risks of bed-sharing. A letter was mailed by DHHS to health care providers, urging them to counsel families accordingly. Baby Blossoms in Omaha launched a campaign specific to bed-sharing as a risk for sudden unexpected infant deaths.

The 2006 legislative session yielded a new law with several provisions related to SIDS, sudden infant death, and shaken baby syndrome. LB 994 included provisions requiring: training on SIDS, Shaken Baby Syndrome, and child abuse for licensed child care providers; inclusion of SIDS and Shaken Baby Syndrome information in Learning Begins at Birth, a booklet provided to all new parents through a collaboration of the Nebraska Department of Education and HHSS; hospital-provided information to parents of newborns via video and written materials on sudden infant death, shaken baby syndrome, dangers of bed sharing, and other related risks; and a public awareness campaign regarding SIDS and Shaken Baby Syndrome. The Child Care Licensing unit took the lead on the child care training provision, and the Lifespan Health Services, along with Protection and Safety, took the lead on the other provisions. During FFY 2007, materials were developed and disributed to hospitals, and in FFY 2008 the Department continued to maintain resources for hospitals and other interested providers.

Reducing rates of infant mortality and eliminating disparties for SIDS and other sudden unexpected infant deaths was included as a goal for the competitive RFA for community-based MCH projects, issued May 2008. Applicants could choose two associated outcomes related to this performance measure: health and human service providers deliver consistent, accurate messages on safe sleep practices for infants; and parents and other caregivers routinely provide safe sleeping environments for infants. None of the applicants specifically addressed the goal or associated outcomes. But a local FIMR project was funded in a rural area of the state, which will provide additional information to address associated risk factors for SIDS and SUID. This is the second local FIMR project in Nebraska, with the other in operation in an urban area (Omaha/Douglas County).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued support of SIDS/SUID and safe sleep provisions of LB 994, including hospital based education materials.			X	
2. Douglas County Health Department and Omaha Baby Blossoms continued to promote "Nothin' but Baby" campaign.			X	
3. Additional local FIMR project initiated and funded via Title V, which will aid in further developing local strategies to reduce SIDS/SUID among at risk populations.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Department continues to maintain and support the provisions of LB 994. Omaha Baby Blossoms continues its educational and informational campaign with partners such as Omaha Healthy Start. Nebraska's Child Death Review Team and the two local FIMR projects continue to identify factors associated with SIDS and SUID.

The Infant Mortality Disparity Work Group is examining factors associated with higher infant mortality rates among African American and Native Americans, including SIDS/SUID.

c. Plan for the Coming Year
The Infant Mortality Disparity Work Group will complete its planning activities, including the development of logic models for priority strategies. Utilizing this work, and information gathered and analyzed by the Child Death Review Team and the two local FIMR projects, the Department will continue to develop and enhance educational and informational efforts to reduce risk factors associated with SIDS and SUID.

State Performance Measure 8: *The percent of African American women beginning prenatal care during the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	90	79.5	69.9	71.3	60.4
Annual Indicator	72.2	68.6	58.8	58.4	54.4
Numerator	1114	1033	1030	1069	946
Denominator	1543	1505	1752	1831	1739
Data Source					Birth file
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	55.5	56.6	57.7	58.9	60

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births). Nearly 7% of the data for this PM is missing/unknown.

Notes - 2006
Nearly 10% of the data for this PM is missing/unknown.

a. Last Year's Accomplishments
Baby Blossoms and Omaha Healthy Start continued to provide leadership in improving prenatal and preconception care for women, with particular attention to disparities in outcomes experienced by African American women. Title V funds continued to support the Maternal Care project. The Lifespan Health Services and the Child Death Review Team Coordinator continued to work with Baby Blossoms and the Douglas County Health Department in conducting a FIMR project, which continues to yield information on access issues for at-risk women.

Efforts continued to better promote the Healthy Mothers, Healthy Babies help line, incorporating outreach and public awareness messages related to prenatal care. Yet use of the help line has not increased significantly. Consequently, an objective to asses use of the helpline was incorporated into the First Time Motherhood/New Parents Intitiative grant application. The question to be asked is: Have 800 phone lines become obselete in an era of internet, text messaging, and other electronic media.

The RFA for community-based MCH projects had a focus on life course approaches, including pre and interconception care. This focus is in accordance with a shift to earlier support of women

and their husbands/partners, prior to pregancy. Women who are engaged in their care and receive supportive health information early will with some degree be more likely to seek prenatal care early when they do become pregant.

A TANF funded project administered by the Lifespan Health Services Unit continued as a pilot. The project funded in the Omaha area provided services to women who are pregnant or believe they may be pregnant, including referrals to prenatal care.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborated with local projects including Omaha Baby Blossoms and Omaha Healthy Start.				X
2. Promoted and supported data analysis to better understand access issues, such as Omaha's FIMR project and a newly funded local FIMR in a rural area of state.				X
3. Administered TANF funded project for pregnant women and women who believe they are pregnant, including outreach and referral components.		X	X	
4. Healthy Mothers, Healthy Babies help line promoted.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Infant Mortality Disparity Work Group was formed, and is currently examining factors associated with higher rates of preterm birth, low birth weight, and infant mortality among African American and Native American women. By late FY 2009 or early FY 2010, the work group will develop logic model for priority strategies to improve birth outcomes and reduce disparities.

c. Plan for the Coming Year
Priority strategies identified and developed by the Infant Mortality Disparity work group will guide programming in 2010. Lifespan Health Services will continue to work with its partners, including Douglas County Health Department, Omaha Baby Blossoms, and Omaha Healthy Start on collaborative interventions to improve access to quality prenatal care.

State Performance Measure 9: *Hospitalization for unintentional injuries (per 1,000) for children and adolescents*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			110.4	110.2	109.8
Annual Indicator	111.7	117.5	118.6	129.8	

Numerator	51706	55225	55890	61254	
Denominator	462820	469913	471382	471930	
Data Source					Hospital Discharge, Census data
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	129.3	124.7	122.3	119.8	117.4

Notes - 2008
HDD will be available in October 2009.

Notes - 2007
HDD will be available in October 2008.

Notes - 2006
HDD will be available in October 2007.

a. Last Year's Accomplishments
The childhood fall prevention program has been successful at distributing safety devices and educating parents on the dangers of childhood falls. Safe Kids Nebraska awarded mini-grants to programs focusing on the following areas: development, fall prevention, and fire safety. This allowed Safe Kids coordinators to expand their efforts to address new risk areas. These mini-grants gave programs opportunities to reach high-risk population that are often left out of mainstream programming.

The Child Death Review Team continued its work to assess preventable child deaths, including unintentianal injuries.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborated with Injury Prevention Program in promoting Safe Kids activities, such as child vehicle safety and fall-related injury prevention.			X	
2. Continued analysis of childhood injuries as part of Child Death Review Team.				X
3. Safe Kids program awarded mini-grants to support local injury prevention activities.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
A higher level of funding for mini-grants was awarded this year. Safe Kids Nebraska awarded six grants to local Safe Kids programs and local health departments. These projects address fall prevention, bike and wheeled sports safety, and fire and burn prevention.

This summer the Safe Kids Nebraska program will initiate a "Childhood Injury Report." With allocation from the Preventative Health and Human Services Block Grant, this report will help

further assess and evaluate current programming across the state.

The Child Death Review Team has noted trends in house fires impacting some populations, and the coordinator has initiated conversations with the State Fire Marshall on possible strategies.

The State Title V/MCH Director is working with the Injury Prevention Program to prepare an application for CDC funding to build capacity in the area of childhood injury prevention.

c. Plan for the Coming Year
Safe Kids Nebraska will continue to collaborate with local health departments and Safe Kids programs throughout the state to prevent unintentional injuries.

Should funding be received from CDC to improve capacity to prevent childhood injury prevention, new activities may include but not be limited to: expanded stakeholder engagement in injury prevention planning and policy development, improved data collection via hospital discharge data reporting, and capacity development with local health departments.

State Performance Measure 10: *Hospitalization for intentional injuries (per 1,000) for children and adolescents (age 1-19)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			5	4.9	4.8
Annual Indicator	4.1	3.9	4.1	3.9	
Numerator	1908	1835	1917	1862	
Denominator	462820	469913	471382	471930	
Data Source					Hospital Discharge, Census data
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3.8	3.7	3.7	3.6	3.5

Notes - 2008
HDD will be available in October 2009.

Notes - 2007
HDD will be available in October, 2008.

Notes - 2006
HDD will be available in October, 2007.

a. Last Year's Accomplishments
During 2006 LB 994 was passed, which included several provisions related to prevention and early detection/intervention of child abuse with a specific emphasis on shaken baby syndrome. Provisions include training requirements for licensed child care providers, inclusion of information in packet provided to newborn parents by HHSS/NE Dept. of Education titled "First Connections with Families - Learning Begins at Birth," parents viewing a video and written materials in health facilities prior to discharge of a newborn, and a public awareness campaign. Child Care

Licensing, Lifespan Health Services, Protection and Safety, and Communications staff of DHHS worked on various aspects of these requirements. In addition, the Children's and Families Foundation lead an effort to develop and promote training and awareness of child abuse prevention/detection/referral among a wide range of early childhood care and education providers. These activities, begun in 2006, continued through FFY 2008.

The Title V/MCH Director actively participated in the Prevention Partnership, coordinated by the Children and Families Foundation. The Partnership developed an action plan for implementing strategies from the Statewide Child Abuse Prevention Plan. Promotion of the plan through public engagement and the identification of best practices were priority actions for the year.

The appropriations bill passed by the Legislature and signed by the Governor included $600,000 per year for SFYs 2008 and 2009 to expand home visitation as a child abuse and neglect prevention and early intervention strategy. Lifespan Health Services contributed to the development of a Request for Bids for these home visitation services. Contractors were selected, with these contracts supported with State General Funds and administered by the Division of Children and Family Services.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued to support shaken baby syndrome and child abuse prevention provisions of LB 994, including hospital based education.			X	
2. Continued collaborations with Protection and Safety and the NE Children and Families Foundation, through the Prevention Partnership, to promote child abuse prevention materials, curricula, and public awareness.			X	X
3. Collaborated with Protection and Safety on guidelines for home visitation as secondary prevention for abuse and neglect.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The work of the Prevention Partnership continues, with an emphasis on promoting evidence based strategies. An Outcome Accountability Seminar for key child abuse prevention stakeholders is scheduled for the week of July 13. Continue to support hospitals and child care providers in carrying out the abuse and neglect prevention provisions of LB 994.

c. Plan for the Coming Year

Since home visitation continues to be considered a priority strategy to prevent child abuse and neglect by Nebraska stakeholders, Lifespan Health Services will continue its collaborative work to assess effectiveness of existing programs and fidelity in implementing evidence based models.

E. Health Status Indicators

Introduction

/2010/ As the comprehensive needs assessment process begins the Health Status Indicators will be utilized as the foundation of indicators to build on to describe the poplution as well as some health outcomes. //2010//

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	7.1	7.0	7.1	7.0	7.1
Numerator	1859	1793	1910	1894	1869
Denominator	26323	25751	26723	26925	26388
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

Out of state resident births are not yet in the data file (1000+ births).

Narrative:

/2010/ Low weight birth rates in Nebraska declined throughout the 1970s and 1980s, before reversing direction in the 1990s and during the present decade. Long-term trends show that Nebraska's annual low birth weight rate has increased steadily since falling to an all-time low of 52.8 in 1990.

Nebraska's 2007 (most recent finalized data) live births included 466 sets of twins, 17 sets of triplets, and 1 set of quadruplets. Nebraska has experienced increasing numbers of multiple births in recent years. By comparison, Nebraska recorded 281 sets of twins and 5 sets of triplets in 1987, just 20 years ago.

Source of data is Nebraska Vital Statistics.
//2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	5.0	5.2	5.4	5.2	5.3
Numerator	1274	1302	1388	1335	1359
Denominator	25333	24889	25807	25912	25464
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births).

Narrative:
/2010/See narrative for Health Status Indicator 01A//2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.3	1.2	1.2	1.3	1.2
Numerator	330	311	333	350	315
Denominator	26291	25751	26723	26925	26388
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Out of state resident births are not yet in the data file (1000+ births).

Narrative:
/2010/ For many years, Nebraska's annual very low birth weight rate showed no consistent trend in any direction, but between 1986 and 1996, it rose by about 50%, and has changed little since.

Source of data is Nebraska Vital Statistics.
//2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.9	0.9	0.9	0.9	0.9
Numerator	217	216	241	237	223
Denominator	25333	24889	25807	25912	25464
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
2010/See narrative for Health Status Indicator 02A//2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	8.6	8.6	8.5	6.7	6.1
Numerator	31	29	29	23	21
Denominator	359029	338806	339983	341855	343908
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
2007 Death file is incomplete, missing out of state deaths and few thousand causes of death.

Narrative:
/2010/Unintentional injuries (commonly referred to as accidents) is Nebraska's fifth leading cause of death. Motor vehicle accidents are Nebraska's leading cause of accidental deaths. Falls are the #2 cause of accidental deaths. Accidents are the leading cause of death among Nebraska residents under the age of 45 years (excluding infants), accounting for 257 (31.2%) of 825 deaths in 2007.

Source of data is Nebraska Vital Statistics.//2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	3.3	5.3	3.8	4.4	1.5
Numerator	12	18	13	15	5
Denominator	359029	338806	339983	341855	343908
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

2007 Death file is incomplete, missing out of state deaths and few thousand causes of death.

Narrative:
/2010/Total number of death due to MVC in 2008 was 208. See narrative for Health Status Indicator 03A. //2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	31.2	27.0	30.4	29.5	22.1
Numerator	83	73	81	78	58
Denominator	266314	270686	266705	264334	262190
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
2007 Death file is incomplete, missing out of state deaths and few thousand causes of death.

Narrative:
/2010/See narrative for Health Status Indicator 03A //2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	244.5	262.7	279.7	267.1	
Numerator	878	890	951	913	
Denominator	359029	338806	339983	341855	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 HDD data is released in October of 2009.

Notes - 2007
2007 HDD data is not available until October, 2008.

Notes - 2006

Hopspital Discharge Data is unavailable unitl October 2007.

Narrative:
/2010/ The leading causes of unintentional injuries to children 14 and under are traffic incidents (including children as occupants, pedestrians, and bicyclists), fire and burns, drownings and near drownings, fall, poisonings, choking/suffocation/strangulation, and sports and recreation injury. //2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	8.6	19.5	9.7	16.7	
Numerator	31	66	33	57	
Denominator	359029	338806	339983	341855	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 HDD data is released in October of 2009.

Notes - 2007
2007 HDD data is not available until October, 2008.

Notes - 2006
This is Inpatient - E code data

Narrative:
/2010/ According the Nebraska Department of Raods younger drivers are involved in a disproportionate number of crashes. In 2007, 51.5% of the drivers involved in crashes were age 34 or younger. Drivers in the youngest age bracket, ages 15 to 24, had the highest percentage involvement of all age groups in both all crashes (32.1%) and fatal crashes (30.9%) during 2007. In 2007 nearly 67.4% of all non fatal injuries were suffered by persons between the ages of 15 and 44.//2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	75.5	75.0	63.0	68.3	
Numerator	201	203	168	179	
Denominator	266314	270686	266705	262190	
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 HDD data is released in October of 2009.

Notes - 2007
2007 HDD data is not available until October, 2008.

Notes - 2006
This is Inpatient E Code data

Narrative:
/2010/ See narrative for Health Status Indicator 04B//2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	21.8	21.0	23.6	21.9	24.7
Numerator	1376	1340	1494	1386	1548
Denominator	63119	63809	63225	63223	62618
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
/2010/ State rates continue to increase with an overall female rate of 422.5/100,000. The highest rates occur in Douglas County (827.5/100,000 among all females (2007)) which is nearly 2 times higher than any other County and the State rate.//2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	6.8	7.1	8.1	7.9	8.6
Numerator	2048	2163	2374	2296	2465
Denominator	299816	302777	292794	290046	285519
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
/2010/See narrative for Health Status Indicator 05A.//2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	27554	23907	1649	437	612	29	920	0
Children 1 through 4	104538	89405	6910	2402	2192	123	3506	0
Children 5 through 9	121352	105956	7260	2010	2267	115	3744	0
Children 10 through 14	118018	103825	7164	1626	2129	89	3185	0
Children 15 through 19	128885	115222	7466	1796	1871	132	2398	0
Children 20 through 24	133305	120393	6876	1632	2418	121	1865	0
Children 0 through 24	633652	558708	37325	9903	11489	609	15618	0

Notes - 2010

Narrative:
/2010/ Source of data is US Census 2008 Population Estimates. //2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	23335	4219	0
Children 1 through 4	87808	16730	0
Children 5 through 9	104666	16686	0
Children 10 through 14	104492	13526	0
Children 15 through 19	117657	11228	0
Children 20 through 24	98226	10045	0
Children 0 through 24	536184	72434	0

Notes - 2010

Narrative:
/2010/ Source of data is US Census 2008 Population Estimates. //2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	19	4	9	0	0	0	0	6
Women 15 through 17	655	336	85	29	4	0	0	201
Women 18 through 19	1582	1008	197	52	15	0	0	310
Women 20 through 34	21155	16736	1324	270	395	0	0	2430
Women 35 or older	2993	2419	124	24	102	0	0	324
Women of all ages	26404	20503	1739	375	516	0	0	3271

Notes - 2010

Narrative:
2010/Among Nebraska women giving birth to their first child, the average age has hardly changed during the present decade, from 24.5 years in 2000 to 24.6 years in 2007, after much larger increases were recorded during the 1970s and 1980s. Among Nebraska women giving birth to their second and third children, the trends are much the same: in both instances, the average age rose during the 1970s, 1980s, and into the early 1990s, but has changed little since the mid-1990s. In fact, the average age of Nebraska women giving birth to their second child was 27.4 years in 2007, compared to 27.6 years in 1995 and 2000. For Nebraska women bearing a third child, the average age was 29.3 years in 2007, compared to 29.5 years in 1995 and 29.3 years in 2000.
Although Nebraska women today are having children later than earlier generations, the majority of all births still occur among women in their twenties. In 2007, women 20-29 accounted for 57.8% of all Nebraska live births, compared to 31.8% for women 30-39, 8.6% for teenaged women, and 1.8% for women 40 and older.

Source of data is is Nebraska Vital Statistics. //2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	12	7	0
Women 15 through 17	401	253	1

Women 18 through 19	1179	402	1
Women 20 through 34	18059	3079	17
Women 35 or older	2603	386	4
Women of all ages	22254	4127	23

Notes - 2010

Narrative:
/2010/Nebraska's increasing number of live births is largely the result of a surge in the number of live births within the state's Hispanic population. Comparison of 2007's live birth data with 1994 (the year that the current upward trend in live births began) show that live births among Hispanic women rose from 1,378 to 4,065, a 195% increase, while live births among non-Hispanic women rose from 21,753 to 22,870, a 5% increase. This trend is most likely the result of Nebraska's expanding Hispanic population, which has tripled in size since 1990.

Source of data is Nebraska Vital Statistics. //2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	136	100	29	2	1	0	0	4
Children 1 through 4	37	27	6	3	0	0	0	1
Children 5 through 9	11	10	1	0	0	0	0	0
Children 10 through 14	15	12	2	0	0	0	0	1
Children 15 through 19	72	56	11	3	1	0	0	1
Children 20 through 24	93	70	15	3	2	0	0	3
Children 0 through 24	364	275	64	11	4	0	0	10

Notes - 2010

Narrative:
/2010/Source of data is Nebraska Vital Statistics.//2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	115	21	0
Children 1 through 4	30	7	0
Children 5 through 9	11	0	0
Children 10 through 14	12	3	0
Children 15 through 19	64	8	0
Children 20 through 24	83	10	0
Children 0 through 24	315	49	0

Notes - 2010

Narrative:
/2010/ Source of data is Nebraska Vital Statistics. //2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	500347	438315	30449	8271	9071	488	13753	0	2008
Percent in household headed by single parent	13.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2007
Percent in TANF (Grant) families	100.0	38.3	30.9	6.1	1.5	0.1	1.4	21.7	2008
Number enrolled in Medicaid	142790	101158	23725	6450	2113	147	1571	7626	2008
Number enrolled in SCHIP	38439	30282	4620	993	565	27	290	1662	2008
Number living in foster home care	4195	2458	769	292	27	0	100	549	2008
Number enrolled in food stamp program	65959	36181	13701	3038	764	64	809	11402	2008
Number enrolled in WIC	56806	35778	6642	9596	741	151	0	3898	2008
Rate (per 100,000) of juvenile crime	3530.9	3659.1	10906.7	6183.4	669.5	0.0	0.0	0.0	2007

arrests									
Percentage of high school drop-outs (grade 9 through 12)	1.7	1.2	4.0	3.1	1.2	0.0	0.0	0.0	2008

Notes - 2010

Narrative:
/2010/ Sources of data is US Census 2008 Population Estimates, US Census American Community Survey, Nebraska Department of Health and Human Services Data (Medicaid, Foster care, food stamp, and WIC), NE Crime Commission, and the Nebraska Department of Education. //2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	437959	62389	0	2008
Percent in household headed by single parent	0.0	0.0	13.5	2007
Percent in TANF (Grant) families	16.0	19.9	64.1	2008
Number enrolled in Medicaid	100446	34698	7626	2008
Number enrolled in SCHIP	26104	10673	1662	2008
Number living in foster home care	494	831	2870	2008
Number enrolled in food stamp program	12901	10485	42573	2008
Number enrolled in WIC	37088	19716	2	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	3530.9	2007
Percentage of high school drop-outs (grade 9 through 12)	0.0	3.1	0.0	2008

Notes - 2010
Ethnicity is not collected

Narrative:
/2010/ Sources of data is US Census 2008 Population Estimates, US Census American Community Survey, Nebraska Department of Health and Human Services Data (Medicaid, Foster care, food stamp, and WIC), NE Crime Commission, and the Nebraska Department of Education. //2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	**Total**

Living in metropolitan areas	273309
Living in urban areas	379919
Living in rural areas	77187
Living in frontier areas	43241
Total - all children 0 through 19	500347

Notes - 2010

Narrative:
/2010/Source of data is the US Census 2008 Population Estimates. Geographical distinctions as determined by NDHHS analysts. //2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	1751000.0
Percent Below: 50% of poverty	4.4
100% of poverty	5.5
200% of poverty	16.1

Notes - 2010

Narrative:
/2010/ Source of data is US Census Current Population Survey. //2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	489000.0
Percent Below: 50% of poverty	6.7
100% of poverty	6.1
200% of poverty	17.4

Notes - 2010

Narrative:
/2010/ Source of data is US Census Current Population Survey. //2010//

F. Other Program Activities

The Perinatal, Child and Adolescent Health (PCAH) Program, within Lifespan Health Services, continues to contract with Nebraska Methodist Hospital to provide the Healthy Mothers/Healthy Babies Helpline, Nebraska's toll-free telephone line, as required by statute. The PCAH Program Manager is the state-level contact person for the helpline. The HMHB Helpline provides 24-hour

nurse-operator service to the MCH population statewide regarding health care questions, and information and referral for the following: Title V and Title XIX providers, Kids Connection, newborn screening disorder-specific information, and folic acid supplementation. Monthly call report data are tracked and analyzed in order to guide publicity efforts. When the line first began in 1992, calls averaged 7 per month. Call frequency peaked at 880 in FY 2000 with a steady decrease to 415 for FY 2004. Year-to-date in FY 2005, there have been 214 calls to the Helpline. PCAH staff has been assigned to analyze the data to identify reasons for the downward trend in usage, to research how other states promote their helplines, and to organize a committee to develop a marketing plan to promote the Nebraska Helpline. PCAH and MCH Planning & Support staff will continue to collaborate to take measures to increase use of the HMHB Helpline in FY 2006.

/2008/ The HMHB brochures, posters, and magnets have been redesigned. Brochures are available in English and Spanish. The Community Health Nurse III sent a cover letter and sample materials to over 2,300 Nebraska physicians, nurses, health departments, and agencies to promote the helpline. Other promotion efforts included a HMHB webpage and a presentation to WIC agency directors. The HMHB helpline number is listed in the community service pages of local telephone books, and an ad was placed in the Journal-Start Baby Steps publication which reaches families in southeastern Nebraska. To date, over 11,000 brochures have been sent to clinics and agencies. Calls continued to decline in FFY06, however, with recent promotion efforts they are increasing for FFY07. There were 207 year-to-date in FFY07 compared to 136 during this same time period in FFY06. The helpline is also being promoted through the Nebraska Perinatal Depression Project website, brochures, posters, and exhibit. HMHB call staff received one hour of training on perinatal depression earlier this year. The CHNIII will continue to monitor call reports and promote the use of the helpline. //2008//

/2009/The HMHB line received 306 calls during FFY08. To promote the helpline, posters, brochures, magnets and table tents were designed and distributed to health providers, local health departments and agencies across the state. During FFY07, 393 posters, 13,309 English brochures, 4,275 Spanish brochures, 8,288 magnets and 201 table tents were sent out. The HMHB number appears in "blue pages" in phone books across the state, and a webpage describing these services appears on the DHHS website. The phone number is also promoted in the perinatal depression public awareness consumer resources.//2009//

/2010/PCAH continued to support the Healthy Mothers, Healthy Babies (HMHB) Helpline through a contract with Nebraska Methodist Health System. This toll-free telephone number is for the use of parents to access information as required by Title V. The HMHB helpline provides 24-hour nurse-operator service to the MCH population statewide and received 412 calls during FFY08. The helpline was promoted through a press release in July 2008 and an article in the "What's Up" newsletter in November 2007.The HMHB number appears in "blue pages" in phone books across the state, and a webpage describing these services appears on the DHHS website. The phone number is also promoted in the perinatal depression public awareness consumer resources.
The social marketing contract funded under the First Time Motherhood/New Parents Initiative grant includes an evaluation of use of toll free numbers by young women, ages 16 to 25, to determine if this method of accessing information is still viable in comparison to use of the internet.//2010//

Title V funds have supported a variety of public health infrastructure developments for some time. Nebraska has been recognized nationally for its great strides in recent years to develop statewide local health departments with tobacco settlement funds. In the previous three years, a portion of Title V funds were set aside for subgranting with the local health departments eligible to receive Tobacco Settlement funds. An MCH capacity-building focus continues with the LB 692 recognized health departments. The funding mechanism with local health departments shifts to contracts from subgrants and the level of Title V funds for MCH community-level infrastructure increases in FY 2006. Contract negotiations with individual health departments will take into

account the current infrastructure level and an assessment of the capacity-building activities needed to continue a steady expansion alongside the tobacco settlement investment. As for other community-based organizations, a requirement for receipt of Title V funds is that these organizations communicate their service plans with their local health department and identify if sufficient capacity exists to support its plan. Title V also continues to support infrastructure at the state-level by internal allocations to 14 programs/administrative units.

Staff of MCH Planning & Support provided technical assistance in Program Development (logic model). Conducted by Ron Mirr, M.S.W., the workshops were held in November 2004 in Columbus and North Platte. In collaboration with the Office of Minority Health, the two-day training was repeated in Lincoln in May 2005 for Native American communities. Process evaluations were highly favorable from participants at each of the three sites. An outcome evaluation indicated that the majority have used skills in the six months post-training.

/2007/ Logic model planning was required for the community-based subgrant applications. Eight community-based organizations and the four federally-recognized Native American Tribes headquartered in Nebraska were awarded funds for the three-year funding period FY2006-2008. Subrecipients report quarterly by providing updates to their logic model workplans, and provide data on performance measures by the final report. //2007//

A primary role of MCH Planning & Support is subrecipient monitoring, as required by the Office of Management and Budget (OMB), and described in the OMB Circulars. As part of NHHS single-agency audit, Title V/MCH has been diligent in its efforts to clear an earmarking audit finding. NHHS with the assistance of MCH Planning & Support has submitted public comment to OMB by suggesting changes to the OMB A-133 Compliance Supplement. The recommendations, if incorporated by OMB, would assist auditors in the correct interpretation of the Title V earmarking requirement. The unresolved audit finding on earmarking puts Nebraska at risk of paying back any questioned costs, which NHHS maintains is unknown due to the incongruent forms, instructions, and audit guidance approved by OMB.

/2007/ Nebraska again suggested changes to the OMB A-133 Compliance Supplement, and to the MCH/Title V Guidance and Forms, OMB #0915-0172, including the financial reporting forms. None of the recommendations were incorporated, so the audit finding is unresolved. //2007//

In FY 2004, MCH Planning & Support worked with the University of Nebraska--Lincoln (UNL) Bureau of Sociological Research to negotiate "social capital" questions on their annual statewide phone survey. The Bureau has conducted the Nebraska Annual Social Indicator Survey (NASIS) for over 25 years, but had not previously selected questions of this nature. The Bureau added seven core questions on the Fall 2004 NASIS to establish a baseline. Results will help guide activities to increase civic participation, as a correlate to public health, and identify methods for public input on the Title V plan.

/2007/ A Social Capital report prepared in 2006 will be utilized in planning. //2007//

Using models identified in a report commissioned with the University of Nebraska Public Policy Center, the Office of Family Health will be the catalyst for a Nebraska-based "virtual MCH institute" if sufficient implementation funds are identified. The institute will be responsible for creating and maintaining MCH capacity with collaborative partners at individual, community, and statewide levels.***/2010/Comments provided during the preparation of this annual report/application include recommendations to further pursue this or similar concepts. Further planning will this occur during FY 2010.//2010//***

G. Technical Assistance

With the five-year comprehensive needs assessment completed earlier this year, focused attention must now be given to strategy development. For many of the ten identified priority

needs, programmatic and system level planning processes are underway, which the Offices of Family Health and Home and Community Based Services for Aged and Physically Disabled will engage in and utilize for determining mid and long term strategies. For instance, the Nebraska Cardiovascular Health Program published earlier this year a plan for nutrition and physical activity. This plan will guide the selection and implementation of strategies to address overweight among women, children and adolescents. Similarly, HHS Protection and Safety has begun development of a child abuse prevention plan, and will be collaborating with the Office of Family Health in its preparation.

As described in the needs assessment, specific attention was given to assessing MCH capacity to carry out the ten essential public health services, using the CAST-5 tool. Subsequently, the Office of Public Health led the assessment of the State Public Health System using the National Public Health Performance Standards. This latter process will be used to develop a new Nebraska Public Health Strategic Plan. With the wealth of information derived from these parallel, complementary processes, Nebraska is in an excellent position to create a strategic plan crafted specifically for MCH infrastructure capacity building. To do so, though, technical assistance is needed on bridging the two assessment processes and linking State Public Health System Planning with MCH capacity building planning.

Nebraska is therefore requesting technical assistance to design next steps in a MCH strategic planning process. Possible sources of the technical assistance would be the Women's and Children's Health Policy Center or the Oregon Office of Family Health. Specific assistance needed would be: means for doing a cross-walk between the two previously completed assessments; recommendations on any follow-up/targeted assessment; and a process for moving from the assessment findings to an integrated State Public Health/MCH strategic plan.

/2007/ During 2006, a number of related planning activities have occurred that impact next steps for MCH/CSHCN strategic planning. Well underway is a comprehensive state level planning process to update Nebraska's Turning Point Plan. The updated plan will provide strategic direction for Nebraska's public health system for the next five years. Secondly, operational planning is occurring jointly between Health and Human Services Regulation and Licensure and Nebraska's local health districts, to map out infrastructure and capacity needs and relative responsibilities for the next ten years. Finally, the MCHB planning workshop offered in Kansas City in June provided useful background in MCH specific planning strategies.

Nebraska continues to need and is requesting technical assistance in designing next steps in MCH strategic planning. The preferred source of technical assistance is the Family Health Outcomes Project in California, specifically Judith Belfiori and Gerry Oliva. Their consultation to our needs assessment process was valuable and forms a strong foundation for next steps in planning. Their prior experience with our state and stakeholders will place them in a good position to provide effective consultation and facilitation. //2007//

/2008/ Late in FY 2006, Nebraska Title V/MCH and CSHCN obtained the consultant services of Judith Belfiori and Gerry Oliva, using existing resources to finance the consultation. The strategic planning process is now underway.//2008//

/2009/Nebraska Title V/CSHCN is requesting that the Maternal & Child Health Bureau (MCHB) in the Health Resources and Services Administration (HRSA) provide consultation to assist with the development of a transition program for youth with special health care needs to transition into adulthood in the areas such as employment, medical services, home and community support to enable them to live independently and participate as members of the community. //2009//

/2010/Lifespan Health Services Unit and its Adolescent Health Program are requesting technical assistance to continue its adolescent comprehensive systems initiative. The development of the model started in FY 2009 with the support of an AMCHP mini-grant. The Early Childhood Comprehensive Systems (ECCS) framework was utilized as a starting

point. To date, two stakeholder meetings have produced a preliminary structure, which requires further refinement, followed by development of indicators and a process for moving ahead with strategic planning using comprehensive systems structure. Potential consultants includ Kristin Teipel, Konopka Institute, and Sharron Corle, AMCHP.

Either as an additional or as an alternative request, Lifespan Health Services Unit is seeking technical assistance to resume earlier work to form a MCH/CSHCN collaborative that connects stakeholders in a consistent and ongoing manner, to enhance communication and collaboration, to build leadership capacity, and to further augment and/or connect the various smaller partnerships that exist to promote the health and well being of the MCH and CSHCN populations. The nature of the technical assistance would be to facilitate a review of models, elicit input from stakeholders, and assist in identifying structure, governance, and operational aspects of the collaborative.//2010//

V. Budget Narrative

A. Expenditures

Nebraska has longstanding concerns with the budget and expenditure forms and instructions. Subsequently, the narrative in Sections V. A & V. B remains much the same as in the past two years. Our concerns stem from incongruent requirements of an annual report for a grant with a two-year period of availability of funds. Despite our best efforts to clarify and communicate concerns over time, to-date we believe these attempts have failed to be understood. We submitted written comments and recommended changes to Federal entities involved in the review, revisions, and re-approval of the Guidance and Forms in May 2003, although no significant revisions were made to the financial portion of the Guidance and Forms. As a result, this narrative attempts to re-clarify the limitations of the financial forms, as much to justify expenditures of Nebraska's Title V funds for FY 2004.

Our longstanding concerns were heightened for FY 2000 and FY 2001. Audits of those years resulted in Federal findings that Nebraska was not in compliance with the statutory earmarking requirements. The corrective action plan to resolve the finding was an extensive commitment of Title V administrative staff time, in consultation with a respected authority on federal policies affecting acquisition, administration and audit of Federal grants. We continue to strive for audit resolution for Nebraska, and we believe ultimately to improve the utility of the information while minimizing the reporting burden to all states.

The period of availability of the Federal MCH allotment allows expenditures in the fiscal year or the succeeding one, i.e. a two-year period (42 U.S.C. 703(b)). For example, the FY 2004 report should include expenditures of the allotment that can occur during the period October 1, 2003 - through September 30, 2005, although that is 21/2 months beyond the FY 2004 report due date of July 15.

The instructions for the annual report's financial forms are vague and contradictory. Form 3 instructions state: "columns labeled *expended* are to contain the actual amounts expended for the *applicable year*." (Emphasis added). *Applicable year* is not defined in the Glossary. Form 3 feeds into sequentially numbered forms, even further confusing the instructions for Form 4 and Form 5, stated: "enter the budgeted and expended amounts for the appropriate *fiscal year*." (Emphasis added). *Fiscal Year* is not defined either, although is generally understood to mean a 12-month period for accounting purposes, with a caveat that *Fiscal Year* is a 24-month period for an allotment with a two-year period of availability of funds. Without clear guidance, Nebraska opted to report expenditures "during" FY 2004 (October 1, 2003 - September 30, 2004), a combination of the FY 2003 and FY 2004 allotments. The attached table depicts the overlap of the two-year period of availability of funds with the fiscal year period, relative to the reporting due date. The shaded cells show the context of the expenditures submitted with this report.

/2007/ The shaded cells in the revised Table 1 highlight the problem with the financial reporting requirement in the *annual* report to show compliance with the earmark requirement of an allotment with a *two-year period of funding availability and carry-over authority*. //2007//

Section 506(a)(1) of Title V, Social Security Act [42 U.S.C. 706] states generally the requirement for submitting an annual report. Section 506(a)(3)(E)(b)(1) states that expenditures from amounts received under Title V are to be audited not less than once every two years. The two-year audit period may have been intended to coincide with the period of availability of funds for the Federal allotment. Financial forms re-approved in May 2003 for the Block Grant Guidance & Forms, as part of the required annual report, are not designed for an audit of the two-year period in which an allotment can be expended. This audit limitation is especially critical for the earmarking requirement established in statute. To further confuse the requirement, the terms "payment" and "allotment" are used interchangeably in statute. [Section 705(a)]. Taken together, the provisions

for earmarking and the period of availability of funds make a convincing case that the earmark must be met over the period for availability of funds, not over the single fiscal year in which funds are expended.

There is one especially bothersome aspect of the audit finding, and so the reason for our persistent approach to make clear the problems with the financial forms. The audit finding proposed questioned costs of $96,000 for the FY 2000 audit because the auditor was unable to determine if the State met the expenditure requirement for at least 30% for preventive and primary care services for children. In our response to the proposed finding, we successfully argued that the questioned costs were unknown because the annual report did not require reporting expenditures of the allotment. A year later, without audit resolution, the auditors expanded the finding to include all the earmarks (30-30-10) through a scope limitation. (Note: Nebraska's audit findings are the result of the auditors' inability to test records, nor due to our withholding information or preventing testing.) To-date we have not been required to pay back funds, however, until there is resolution, the finding remains.

Financial reporting in the FY 2004 Report, as in prior years, conforms to the required annual report format showing funds expended in a fiscal year. FY 2004 will be audited in August 2005. The table attached illustrates the incongruent requirements, causing the Federal audit finding for earmarking for three consecutive years, to date.

One possible solution is to maintain two separate record keeping systems, one for the required annual report based on fiscal year payments and another by expenditures of the allotment. Separate record keeping would be unnecessary if the annual reporting forms were revised to reflect the two-year expenditure of an allotment by subcategories of "Types of Individuals" and "Types of Services". Presently, accounting staff assigns codes to distinguish individual expenditures by allotment within a fiscal year. Additional coding could identify earmarked expenditures of an allotment across the two-year period of availability of funds. Pairing allotment with earmark coding would eliminate the need to keep two separate systems to be compliant with auditing and to continue submitting annual reports in the format prescribed by MCHB.

/2007/ It would be inefficient and burdensome to comply with both the annual reporting requirement and a separate accounting for earmarking on the two-year allotment. As part of the clearance review process of the Paperwork Reduction Act, Nebraska again submitted comments and specific recommendations for revisions to the Guidance and Forms that would improve the utility of information and minimize the reporting burden for all respondents, i.e. it impacts all states and territories. None of Nebraska's recommendations were incorporated and therefore the longstanding earmark audit finding continues unresolved. //2007//

The local community subrecipients are monitored by line item budgets and expenditures to achieve the detail and accuracy to monitor Federal funds. Since subrecipient monitoring is also a compliance requirement, it is not an option to minimize reporting by scaling down those reports and only reporting the earmarked, subcategory expenditures. Although somewhat cumbersome to have subrecipients report both by line item and by category expenditures, this appears to be more feasible than to report one way to MCHB and to maintain another method to achieve audit compliance. We have urged that these data elements be reduced to the absolute minimum needed to allow for compliance with the statute authorizing the MCH Block Grant, i.e. the earmarked 30-30-10. Further, we have suggested that the fiscal data required by Section 706(a)(2)(iv) be combined with the requirement and timing for submission of the reporting required under 45 C.F.R. 96.30(b), i.e. OMB Standard Form 269A "Financial Status Report" (FSR). This would enhance the ability of all states to reconcile periodic financial reports submitted to the Federal government with their annual financial statements audited pursuant to OMB Circular A-133. Further, it would create the ability to demonstrate states' current carry-over authority available under Section 703(b) of the statute.

Without the additional accounting records of expenditures by allotment and earmarking, the

auditors relied on the annual report (Form 4) to test if the earmarking requirement was met. Form 4 has two limitations to use it for auditing compliance: 1) expenditures are based on the fiscal year (not the expenditures of an allotment); and, 2) the expenditure column of Form 4 "Types of Individuals" combines the Federal expenditures with expenditures of State match ("Federal-State Partnership"), although earmarking is based on the Federal allocation only. 42 U.S.C. 706(a)(2)(iv). (See also, Legislative Briefing Title V Law Legal Compendium, New MCH State Leaders' Orientation Manual, October 2000, pg. 19). In other words, Form 4 does not identify earmarking expenditures because it is a combination of Federal and State funds, nor does it make the necessary distinction between expenditure of an allotment and expenditures in a fiscal year.

The FSR reflects the obligations and expenditures for the period of availability of funds, although the format does not incorporate the requirement to categorize expenditures by "Types of Individuals" (Form 4), nor "Types of Services" (Form 5), as required by U.S.C. 706(a)(2)(iv). The non-final FSR (due 15 months into and 9 months prior to the conclusion of the period of availability of funds) seeks obligation of unexpended funds for carry-over authority. The FSR is critical to the Form 2 budget and subsequently the remainder of the financial forms driven by it.

Budget-to-expenditure variations (Forms 3, 4, and 5) cannot be explained without discussing Form 2, albeit a budget form in a section to explain expenditures. Specifically, Line 2, Form 2 "Unobligated Balance" is problematic due to misinterpretation of several lines of the FSR, i.e. "Unobligated Balance" and "Unliquidated Obligations," which are similar phrases, but with a distinct difference for budgeting. The FSR seeks the "Unliquidated Obligations," i.e. obligated funds not yet expended. In a non-final FSR, Nebraska calculates "Unliquidated Obligations" as allotment minus outlay. In the final FSR, the same line must be zero. As stated on page 57 of the Block Grant Guidance & Forms, the MCHB instruction overrides the standard instruction for Standard Form 424, Line 15b. ("Applicant") by instructing applicants to report the "Unobligated Balance." That figure feeds Line 2, Form 2. If Form 2 sought the "Unliquidated Obligations" (obligated, unexpended funds) rather than the "Unobligated Balance", the budget would accurately reflect the new allotment plus the carryover from the previous allotment. Accordingly, the definition for "carryover" in the glossary should be revised. Since Nebraska reports zero "Unobligated Balance", our budget reflects only the new allotment. The difference is typically six figures. Nebraska exercises carry-over authority, although is unable to budget carry-over using the present form and instructions, so its grant expenditures exceed budget. A wide variance between budget and expenditures as with previous years, is explained primarily by the incompatible budget and expenditure reporting formats originating with the misinterpretation of the FSR, which feeds Form 2, Form 3, Form 4, and Form 5.

Form 4 requires that administrative costs be reported along with categories of "Types of Individuals". The staff responsible for the administration of Nebraska's MCH Block Grant do not provide services, although administrative costs must be reported among "Types of Individuals Served." Including administrative costs with expenditures for services detracts from the percentage for 30-30 earmarked expenditures could contribute to auditing irregularities. Administrative costs would be more logically and accurately reported on Form 5 as part of the subcategory "Infrastructure." Administrative functions contribute to state-level MCH infrastructure by needs assessment, planning, policy development, monitoring, building information systems, etc.

/2007/ References to specific years are not updated within the text of the original submission in July 2005, although the previous narrative remains valid in all other respects. //2007//

/2008/ Despite the extreme inefficiency and burden to maintain two separate record keeping systems, Nebraska is doing so to clear a longstanding unresolved federal audit finding on earmarking. One record is kept based on fiscal year payments to satisfy the annual report requirement. A second system was created to be auditable for the statutory earmark expenditures of an allotment (with a two-year period of availability). The second record is being

implemented in two steps, i.e. Part I and II. (Note: Because it uses a retrospective methodology, Part I relating to the 2006 grant will actually occur after the completion of Part II relating to the 2007 grant.) Part II: A coding methodology was developed and prospectively implemented for the 2007 grant to record expenditures of earmark categories by grant. The timeline for completion of Part II was March 1, 2007 and was completed in June 2007. The new coding procedures are in effect beginning July 1, 2007. Coding by types of individuals was added to the codes by allotment to capture the earmark expenditures over the two-year period of availability. Expenditures by earmark categories will be calculated for the 2006 grant using a retrospective methodology. The expenditures by earmarked categories, as reported by subrecipients, internal allocated units, and contractors in FY2006 and FY2007, will be applied to payment history for the 2006 grant. The timeline for completion is December 31, 2007. //2008//

/2009/ The accounting code procedures to identify the expenditures by types of individuals has been in effect for one year and will continue as established. The first cycle for coding expenditures within an allotment is expected to be complete in approximately March - April 2009 when the FY 2008 federal allotment will be fully expended.//2009//

/2010/ No specific updates other than to re-affirm our concerns as previoiusly detailed regarding the financial reporting forms. //2010//

B. Budget

Much of what is requested for budget narrative has already been described in the Expenditure narrative, although in it budget features are addressed and clarified as they relate to expenditures. Our determination to make a shift in the context is due to the inextricable relationship of budget and expenditure, and our interpretation that statutory "maintenance of effort" and "earmarking" requirements are based on expenditures. The guidance and forms mistakenly connects these to budget. The Guidance for Section V. "Budget Narrative" confuses these distinctions by instructing the expenditure narrative to precede budget narrative. Logically, expenditures are "subsequent to" budget. Heading Section V. "Financial Narrative" would be more descriptive of the section content as it would be inclusive of budget and expenditures.

Budget and expenditures are necessarily intertwined. Understanding the particular function of budget and expenditure are important for accountability, as the use of funds is based in statutory requirements. It is not the intent to minimize the purpose of budgeting, although we believe it is responsible to emphasize our understanding that accountability is entirely related to expenditures. Expenditures, of course, are legitimized by a realistic budget.

An introductory statement in the budget Form 2 instruction states: "This form provides details of the State's MCH budget and *the fulfillment of certain spending requirements* under Title V for a given year." (Emphasis added.) Contrast budget as a plan for expenditures with actuality being the expenditure of funds. The fulfillment of spending requirements, i.e. "earmarking" and "maintenance of effort", comes with expenditure; it is not a direct result of budget alone. If compliance of earmarking and maintenance of effort were based in budget, although they are not, Form 2 would be further misleading. Due to its limitation to budget carryover (see Expenditure narrative for detail), the earmarkings are percentages of the budgeted allotment, rather than the allotment plus carryover.

Amount, source, and time period are critical components in budget and expenditure. Form 2 seeks a budget overview of funds, including "Other Federal Funds" under the control of the person responsible for the administration of Title V. The format does not allow for subsequent report of actual expenditures of the budget amount of "Other Federal Funds." Further, some of these other Federal funds do not mirror the Title V fiscal year period of October 1-September 30, making it difficult to accurately understand the financial relationships between the various sources and amounts of funds to Title V.

Federal Title V support clearly complements Nebraska's effort. Nebraska's budgeted "maintenance of effort", based on FY 1989 State support, has consistently been surpassed. The source of non-Federal funds is a combination of State Comprehensive Systems and local funds and in-kind support to meet both maintenance of effort and the 3:4 match requirement. The largest single source of State support comes thru the Medically Handicapped Children's Program (MHCP). Other sources of State funds that complement Title V funding include support to the following programs: the Immunization Program for vaccine purchase, Newborn Metabolic Screening Program which also includes a cash fund from screening fees, Reproductive Health Program, and Birth Defects Prevention legislation to support genetic clinics at the University of Nebraska Medical Center.

The inadequacies of the financial forms to produce meaningful and accountable information is further demonstrated between Form 2, Form 3 and Form 4. Compliance with the 30-30-10% earmarkings is suggested on Form 2 budget, although we interpret the statutory earmarking requirements as the expenditure of allotment. The expenditure of the Federal allocation (Form 3) is shown separate from the earmarked categories of expenditures on Form 4, which are a combination of Federal and State funds. Form 4 cannot be used to determine earmarking compliance, as that is based on the Federal allotment alone. Form 5 is also plagued with similiar problems as Form 4, although not in the same statutory compliance since the Form 5 categories are not earmarked. (See Expenditure narrative regarding Form 5 relative to administrative cost and infrastructure.) If administrative costs were incorporated on Form 5, as suggested, Form 5 would need to identify the distinction between budget for Federal and State funds relative to the 10% earmark. We have previously asked on multiple occasions to have a clearer definition of "administrative costs," None of these requests for clarification have been satisfied.

Any significant year-to-year budget variations are difficult to discern, and subsequently to explain, in the present format and instruction limitations to these financial forms.

/2007/ The budget narrative submitted July 2005 remains unchanged. //2007//

/2008/ The budget narrative submitted July 2005 and July 2006 remains unchanged. //2008//

/2009/ The budget narrative submitted July 2005, July 2006, and July 2007 remains unchanged. //2009//

/2010/ No specific updates other than to re-affirm our concerns as previoiusly detailed regarding the financial forms. //2010//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.